DRUG POLICY-

A REFLECTION ON THE INDIAN SCENARIO

National Addiction Research Centre, Mumbai

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DRUG POLICY:

A REFLECTION ON THE INDIAN SCENARIO

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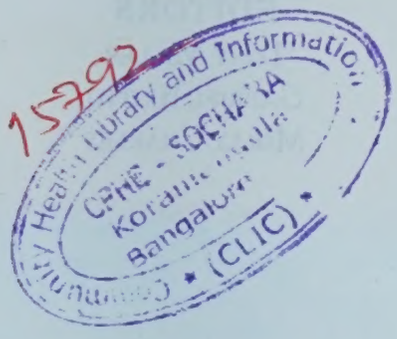

FOREWORD

World over, Governments of all hues (democratic, autocratic...), at all times in history have displayed a penchant for acquiring ever greater powers over their citizens; some do it with a finesse others go about it in the most cussed manner. Equality, fraternity and liberty elude all but a bunch of power elites.

Policy makers and leaders aided by powerful media barons have portrayed drug use in such heinous terms that there is little public debate on the draconian laws being passed to curb addiction. There is a need to analyze the management of drug abuse from a rights based approach. Will we allow the State to dictate what we as citizens, eat and drink and how far we can explore the depths of our consciousness? Where does the freedom of the individual end and where does the power of the State begin?

Centralization is a natural behaviour for governments. With it comes homogenization and negation of cultural differences. In the drug field, we have seen this process inexorably increasing the powers of governments and international organizations in all countries. Globalization of trade may be a recent phenomenon in India, but setting of uniform norms on drug use has been going on for the past ninety years.

This book is a reminder that drug use and abuse is a complex phenomenon in India: it has medicinal, social, religious, functional significance in people's everyday lives. It has been so for centuries. India is huge kaleidoscope of cultures and culture controls human behaviour. The patterns of drug use and its control vary from place to place from people to people.

We are not speaking of some esoteric phenomenon that was there a couple of centuries ago. The paper on drug use in Junagadh and Porbundar points out that tradition has persisted up to the year 2000. Similarly, the papers on cannabis use in Karnataka and opium use in Saurashtra show that despite the operation of the highly flawed Narcotic Drugs and Psychotropic Substances (NDPS) Act for ten years, cultural use of drugs has remained a social fact in the year 1995.

Prevention of drug abuse has to be culture-specific, substance-specific and mode-specific. The papers presented in this volume (despite their stated limitations) give a clarion call to governments and foundations to launch action research on social processes that impinge upon drug use behaviour. The current state of drug use/abuse in most parts of the country is benign. However, national policies on management of drug abuse are based on the worst-case scenario.

There is strong case for ***decriminalizing drug use*** in these pages. None of the papers argue for ***legalization of drugs***. Among the options we have mooted is opening of opium and cannabis registers, licensing and making these two substances available across the country. Very few people seem to know that the NDPS Act and the rules under the Act clearly provide for the issuance of license to addicts and traditional medical practitioners. It is a practical, feasible and the most sensible way of tackling the emerging patterns of drug use, which includes injecting drug use, iatrogenic addictions and an explosion in the consumption of alcohol. The paper on widows of injecting drug users of Manipur presents a shocking picture. Let us not wait for such a scenario to take over the country before we can act.

It is time to discard the type of social engineering – criminalization, marginalization and stigmatization – that we have adopted to deal with drug problem. This paradigm is pernicious and pushes drug users into the arms of the mafia.

Gabriel BRITTO
Director : NARC
2nd October, 2001

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GLOSSARY

Amal: local name for opium, meaning 'rule' or 'control'.

Amaldar: a person who can afford the consumption of amal on a regular basis.

Amal galan/amal garhna: process of dissolving opium in water and sifting it in a customary manner on a wooden stand.

Athiti/mehman: guest (often son-in-law) of any house of the higher castes in the village. A visit by him is a very important and much awaited social occasion. A meeting is organised to mark the occasion. All males and sometimes females come and participate in amal distribution and consumption.

Ayuruveda: one of the three Indian systems of medicine. Ayuruveda has its roots in Vedic scriptures;

Bandhani: one who regularly consumes opium.

Basti: a tribal village.

Balu: a musical instrument associated with the baul movement in the border areas of Orissa, West Bengal and Bihar, whose basic philosophy is to get away from materialism.

Beedi or bidi: a form of cigarette made of tobacco and biri leaves. Popular with the poorer section of society due to its affordability.

Dayaro: opium-drinking gathering.

Dhandia: small cluster of huts made of mud and thatch. In the desert, people do not live in villages, which are away from their farms and fields, like other parts of India. They have big farms and fields and they live in dhandias. Only two or at the most three families live together in these dhandias. One cluster of dhandias is more than two or three Kms away from the other. Such distances and a difficult terrain pose hurdles in maintaining a social life. If justifies an extraordinary respect for a traveler, which is a unique phenomenon in western Rajasthan and in northern Gujarat.

Doda: The dry empty pods of poppy are crushed into powder, soaked overnight in water, filtered several times ritually with a cloth and the juice is drunk. This drink has mild though similar impact; as opium.

Duhas: verses composed by the bard-caste of Charans.

Ganja: (Marijuana) flowering or fruiting tops of the cannabis plant.

Girasdar: Rajput who owns a village(s) presented by a king or prince.
Handia: rice beer.

Holi: religious festival of Hindus during which colours and water are splashed at people. The festival symbolises amity and brotherhood. Hence, during this festival, cannabis products especially bhang is distributed and drunk. Another religious connotation to this festival signifies the pacification of God Shiva.

Bhajan: devotional song

Bhakti: devotion. In this monograph, Bhakti is referred to the movement started in the Middle ages, emphasizing worship of God through simple behaviours.

Bhang cannabis compound derived from the leaves of the Indian hemp/ cannabis sativa.

Bhatti: place for brewing illicit liquor.

Bhog: offering meals to god

Bigha: measurement unit of land (1 bigha = 0.4 acres)

Biradari: community.

Cannabis: the Indian hemp plant, Cannabis Sativa, from which bhang, ganja and charas are obtained.

Charan: a protected caste, known as Deviputras, who perform many of the functions in Saurashtra, performed by the Brahmins elsewhere. In the past they composed poems praising the virtues of opium.

Charas: under Indian law the separated resin, in whatever form, whether crude or purified, obtained from the cannabis plant, includes its concentrated preparation known as hashish oil or liquid hashish.

Chupal: common meeting place in villages.

Chillum: pipe used for smoking tobacco and ganja.

Dacpit: bandit.

Hooka: device for smoking tobacco by drawing the smoke through water- called 'hubble-bubble' after the noise it produces while smoking;

Jagha: place.

Kahar: a caste.

Kurmi: a caste.

Karkhana: workshop

Karigar: skilled worker

Kasumba: saffron colour.

Kasumba pani: opium liquid.

Kathi: a dominant caste.

Lac or lakh: Rs.100, 000.

Maan Manuar: these words are very important in the social life of the rural Rajasthanis and they are very touchy about them. They respectively mean respect, honour and humble hospitality and a collective sitting of the village males organised by them in honour of a guest, a son-in-law or other.

Mahua: traditional drink obtained from the sweet flowers of a tree;

Mahavira: a great warrior, term generally used to describe Lord Hanuman and is synonymous with bravery.

Maulvi: a Muslim priest.

NDPS ACT: Narcotics Drug and Psychotropic Substances Act was promulgated by the Parliament in India in 1985.

NGOS: Non Government Organisations these are non-profit voluntary agencies, which undertake welfare, health and development activities. The ministry of welfare, Government of India provided in 1995 financial assistance t over 275 such NGOs for drug demand reduction activities in the country. The ministry had an outlay to 480 million rupees for five years for this scheme.

Pada: a locality in a village. A single caste group generally inhabits a pada.

Palki: palanquin.

Pan: a popular preparation for chewing, whose three main ingredients are betel leaf, lime and arecanut.

Panchayat: village council.

Panda: a priest.

Pasi: a caste.

Patidar: a peasant caste, which has become dominant in recent years, rivaling the Rajputs/Kathis.

Ponda Sankranti: a festival.

Pradhan: a village head.

Prasad: offering (usually to the Gods)

Puja: worship.

Rajput: a dominant caste in Rajasthan and parts of Gujarat Basically a warrior caste, Rajputs are renowned for their bravery and chivalry.

Rewan / Reyan: collective honour given by the village folks in which amal is dissolved and distributed, followed by several rounds of tea offered by the host.

Rogu: mode of opium consumption by chewing it in granul form.

Rs: Rupee, Indian Currency (one US$ = Rs 35 approx.)

Sadhu/ Sant: person following a Hindu religion, who h renounced the world.

Shiv Ling: symbol of Lord Shiva.

Smack: colloquial term for crude heroin, also known as 'brow sugar'.

Swaminarayan: religious sect founded by Sahjanand Swam (1781-1830), a part of the wider Bhakti movement.

Tibbi: traditional Mohammedan medicine.

Yadava: a caste.

MONOGRAPH 1

CULTURE AND DRUG ABUSE

H.Y. Siddiqui and Subair Meenai

Chapter 1

INTRODUCTION

It is known that human behaviour is culture specific. All cultures generate guidelines, based on a classification of various options in a hierarchical order to signify their collective acceptance or rejection, which serve to influence the behaviour of individuals in all aspects of their lives. For example, each culture specifies what people should eat and drink, the form of consumption, the time of consumption and other rituals, Similar guidelines exist in various cultures for alcoholic drinks and other mind altering substances. In this study, we have attempted to assess the influence of cultural practices on the drug use and to evolve culture specific strategies for treatment and prevention.

Theoretical framework

When anthropologists employ the term 'culture' in a particular society , they have in mind the shared system of meanings that serve as principles and guidelines for behaviour. Kluckhohn (1954) calls it a "blueprint for all of life's activities ". This knowledge makes it possible for people to behave more or less predictably in most given situations (Barrett, 1984).

However, many people, in various contexts, do not behave according to socio-cultural expectations. One could argue that the task of conforming to cultural norms would depend upon how the norms are transmitted, received and internalized. We have made an attempt to explore this complex process to understand how cultural norms are incorporated or rejected in the' performative blueprints' of human beings. We have analyzed the possibilities of action not in conformity with the collective valuation of a culture, such as drug use. We have taken into account situations or conditions which may encourage or discourage such tendencies.

Some anthropologists have devoted considerable attention to the understanding of linkages between culture and conduct (Barrett, 1984) or culture, thought and social action (Tambiah, 1985). Their formulations help us to ponder upon such issues as to whether the ritual use of drugs in some cultures is an indication of its harmony with the culture's collective valuation or whether it is a power or prestige conferring enactment in specific human situations and contexts. It is obvious that if the former is true, the use of drugs will be far more open, frequent and spontaneous, whereas in the latter event, drug use will be confined to a limited section of society. The average person will not be a frequent, spontaneous user on the one hand and the use cannot be taken as culturally determined on the other.

These interpretations bring into focus the problem of attempting to arrive at a simple understanding of the causality of an action, which attributes belief systems as the chief determinant of human conduct. Tobin Horton, who views belief systems as the primary feature of religious life, subjected them to tests of logical coherence and totality in a causal mode. Tambiah finds this too narrow an approach, and one which simply does not take into account the performative logic of any action on its own terms. Tambiah has argued that human beings the world over are, in their actions, simultaneously involved in two modalities, the modality of causality and the modality of performative acts. The validity of the latter rests on social conventions different from those accepted by the scientific community, which simply believes in the supremacy of the natural sciences. The degree of explicitness and self-consciousness of these modalities, their relative weightage, centrality and the hierarchical ordering , may differ from culture to culture, or between social segments within the same society and within the same civilisation at different points of time. Some of the questions which are worth considering are:

Can we unambiguously separate human acts which are' technical-causal' in their objective but 'performative' in their communicative patterning and vice-versa ?

If yes, how are we to interpret their dual patterning and the nature of their efficacy?

Tambiah argues that such questions are better dealt with once we accept 'technical' acts and 'ritual' acts as different kinds of conventional acts, and once we renounce the imperial claim that the best way to understand all categories of ideas or beliefs is by testing how far they constitute logically coherent systems, whose purpose is the explanation of events in the 'causal' mode of predictions and empirical proof. In his presidential address to the American Association for the Advancement of Science, Franz Boaz (1932) emphasised the importance of cultural influences on human behaviour and the individual's reaction to the cultural setting:

"It seems a vain effort to search for sociological laws disregarding what should be called social psychology, namely, the reaction of the individual to culture. They can be no more than empty formulae that can be imbued with life only by taking account of individual behaviour in cultural settings."

In the subsequent development of social sciences, culture received its due share in the study of human behaviour. Three concepts - culture, biological heredity and situation (physical environment and social interaction) – have been

employed in behavioural sciences for explaining the regularities and diversities of human behaviour. At a higher level of abstraction, each of these concepts is a genuine aid to understanding. But when it comes to explaining and predicting concrete phenomena such as drug or abuse, any category will only take us a limited distance. Recognising the interdependence of several variables, social scientists have devised secondary categories, such as life experience, learning and motivation.

All cultures use a classification system of categories which describes the world, and this description implies valuation of moral premises and emotional attitudes translated into taboos, preferences, prescriptions, and prescriptions. The actors (unless they are intellectuals) subscribing to a particular classification and cosmology accept them as natural. Thus the cosmologies and classifications are thoughts which are translated into practices (Tambiah, 1985). In employing and living them, actors, distinguished by status, gender and expectations, act in situational contexts. This means that each actor will classify drugs, drug usage and frequency of use in a particular situational context. In doing so, they face and work through certain anomalies and contingencies of a semantic and pragmatic nature.

Finally, it may be worthwhile to consider the relationship between activities performed under constraint and activities chosen freely, between punishment for non-conformity and recognition for conformity, between what the culture promises and what the culture actually gives, between painful experiences and gratifying experiences, and the relationship between the consideration one gives to the satisfaction of one's own needs as contrasted with the consideration one gives to the satisfaction of other people's needs (Kluckhorn, 1954). These are termed universal elements, present in all human cultures, which are likely to affect the performative blueprints of actors everywhere.

The answer to these questions will help to enhance an understanding of the factors affecting drug use in a community. A strategy of intervention either for treatment or prevention based on such an understanding will consequently be more effective. For example, the knowledge of the type of drug use, the sources of its legitimisation in the society, and the culture specific reasons for its use, will enable us to devise a suitable strategy for treatment and prevention. Thus the strategy of control of opium use in Rahjasthan will be different from the one to be used for prevention of ganja use in Uttar Pradesh or of 'brown sugar' (crude heroin) in an urban area.

The latter part of the study looks at the possibility of community involvement in evolving a strategy of intervention in the area of drug abuse. An attempt has been made to identify people who possess specific information about the problem in a community, the nature and scope of their knowledge and their willingness to act as volunteers. In the Indian situation, as perhaps in most other developing countries, efforts in managing the demand and supply of drugs will depend to a great extent on community involvement in any such endeavour. It is fairly well known that such community efforts have been on the decline in recent years, more so in urban areas. The study has also attempted to explore the trend of community participation and the reasons for change therein.

Methodology

The selection of areas under the study has been done with a view to covering different cultural practices. In order to cover the spatial characteristics, the study includes urban, semi-urban rural and tribal areas. In addition, these reflect the level of development of each category, beginning with the urban at one extreme and the tribal area, being the least influenced by modern economic development, at the other. In order to cover the regional differences, four major states and a Union Territory in India, i.e. Rajasthan, Uttar Pradesh, Madhya Pradesh, Orissa and Delhi have been covered. The research team had flexibility in selecting a specific locality for collection of primary data. These locations were chosen after the research team visited these areas. The sampling therefore is purposive.

During recent workshop hosted by National Addiction Research Centre (NARC), it was found that the survey method was not very helpful in ascertaining incidence rates or the reason for classifying drug use as positive or negative in the cosmological construct (see operational definition below), or its implications for incorporation and rejection in the performative blueprints of the individual. Hence it was decided to conduct case studies of individuals and specific locations, and supplement them with other available data. Guidelines for studying the individual and the community were accordingly developed. An attempt has also been made to study the range of an informed person's knowledge, its authenticity and scope. A separate interview schedule was adopted for the purpose. A number of case studies of individuals and communities were prepared. However, only those found suitable to provide a specific understanding of cultural practices and their impact on drug use are presented here for discussion. Besides taking a look at case studies to ascertain the nature of factors influencing drug use in the case of individuals, an attempt has been made to collect data from the different locations to prepare an area profile of drug use. We would have preferred to supplement these data from the data available on these places in the official records or other literature available on the subject, to authenticate our own observations, but time constraints have precluded it.

This, then, is a preliminary exploratory exercise. The conclusions drawn therefore should be taken as tentative and need further testing.

Operational definitions

Drug: the term has been used to refer to charas, ganja, bhang, opium, and crude heroin/smack./brown sugar.

Traditional/indigenous drugs: the term covers bhang, ganja, charas and opium only.

Modern drugs: refers to brown sugar/smack/ crude heroin.

Addict: a regular user of crude heroin or opium.

Abuser: a person who uses charas, ganja or bhang for non-medical reasons.

Drug addiction: a state of periodic or chronic intoxication detrimental to the individual and society, produced by the repeated consumption of a drug (natural or synthetic) [WHO, 1957].

Culture: the term refers to the specific guidelines which each community/ society evolves for regulating the behaviour of its members.

Community: the term refers to people living within a defined geographical area. At times it may also refer to people belonging to a religion or caste.

Informed person: a person expected to be more knowledgeable by virtue of his/her profession, length of stay in the area, etc.

Cosmological construct: a framework of concepts and relations which treats the universe or cosmos as an ordered system, describing it in terms of space, time, matter and motion and peopling it with gods, humans, animals, spirits, demons and the like.

Situational context: the socio-economic environment of an actor.

Performative blueprint: the actor's selective version of a cosmological construct.

Hypotheses:

Using the concepts of cosmological constructs and performative blue-prints in the context of drug use, we propose the following hypotheses:

- The drug use in a culture will be a direct function of its place in the cosmological construct and its relationship with the performative blueprint of different actors or sets of actors. A culture, for example, where certain drugs are used for healing or for other specific goals, may facilitate the use of drugs by some actors, though based on a different kind of performative logic of its own.

- If certain acts and things are placed in a higher/favourable evaluation category in the cosmological construct and classification, their incorporation in performative blueprints will entail lesser problems in the resolution of anomalies between the two. On the contrary, if the relationship between the place of an action or thing in the cosmological construct is in the lower/disapproved category, its incorporation in the performative blueprints of actors will require greater personality strength.

- The degree of such tension will depend on the idiosyncratic evaluation of the individual actor or group of actors of their own position within a culture/ society.

- Their 'reference' material, which is either written or available in the oral tradition, will further influence the incorporation of elements in performative blueprints which are antithetically placed in the cosmological constructs of a culture.

- The possibility of an action not in conformity with the cultural norms will thus increase or decrease depending upon the changes taking place in the cultural norms and the direction of the change. Further, such changes will be influenced by the nature of the structuring of social relationship in the society.

Chapter 2

COMMUNITY PROFILES OF DRUG USE

A village in Delhi

Khizrabad village is one of the urban villages of South Delhi. The present physical formation of the village is such that on the one side is the New Friends Colony Road and on the other is the building of the All Saints Convent school, while at the back is the river Yamuna. One main lane runs through the whole village, which is connected by some narrow lanes. There is no underground sewerage system. With a few exceptions, all houses are small and their construction is unplanned.

Only traditional caste groups still live in clusters. Hence, there is the Jat lane, the Dhimar lane, the Mallati lane the Kohli camp, etc. Other inhabitants, who have migrated a few decades ago, are scattered all over the village. All are not tenants; many of them have begun to buy and own a space in the village.

The inhabitants, both old and new, do not seem to have a clear idea of the total population of the village. Some of the people think it may be ten to twelve thousand. The total number of voters in the village for the recently concluded Delhi Assembly elections is about five thousand. The young and educated people of the village take this number as a base to determine the total population.

The village, like many others, which are situated on the outskirts of the city, is being used for residential and commercial purposes. It is about one and half kilometers from Jamia Millia Islamia university. For a long time, the Panchayat system has been functional in this village and it has traditionally been headed by the ancestors of Mr. J.S., whom we interviewed. Nearly a hundred years ago a few families came and settled here. Mallahs are prominent among them. Traditionally their main occupation was agriculture; they later sold their land to colonisers.

Mr. J.S. is a member of a well-to-do joint family which is locally called the Mawasi family. They have lived here for several generations. His knowledge about the history of the village, is based on what he has learnt from his forefathers. They had come from a village called Khizir in Haryana and settled here. They are Dhimar by caste. Over a period of time, the family has multiplied into several joint families. A few of them have migrated to other parts of Delhi but many still live here.

Mr.M.S. is a 28 years old member of the Mallah community. He has passed Standard VIII and runs a small grocery shop. He does not sound happy with his present economic activity and desperately wants some other employment. The Mallahs were originally Rajputs. In the early days they took up water carriage and plying boats as their means of livelihood. As there were no bridges, boats were the only way of crossing the river. Hence they came to be known as 'Mallahs'.

Jats, who were the contemporary migrant group, are now left as the biggest caste group of the original inhabitants in the village. Marvaris claim that they had given land to the other two migrant groups to settle down. However, the other groups deny this claim, saying that when they came, the land was lying unclaimed.

These three original groups or inhabitants of the village were followed by the 'outcastes' i.e. the Kohkuism, Jatavas, Yadavas, Kurmis etc. These communities provided the services required by the higher castes.

Social Proximity

In order to determine the span of social proximity within the village, the population can broadly be divided into two parts. One part consists of the original residents, who have been living here for several generations. Others have recently migrated. Social proximity (inter as well as intra-group) is some what metropolitan in character. In the case of the original residents, it is often caste based. The frequency of their interaction with migrants as well as their tenants is very low. They spend more time in their work and are hesitant to interact with outsiders.

Alcoholism in the village

A male respondent, Mr. D., who is over 75 years old, says that male adults of the village have used alcohol on certain occasions for a long time. There have been very few addicted to it; alcoholism, he says, has been more common in the lower caste groups.

Occupation groups

Jats and Dhimars, both male and female, are engaged in dairy work. Some of them, who have acquired modern education, are employed in government services, various professions and in real estate business. The lower castes are involved in petty trade and commerce. Their women work as maidservants in the surrounding residential colonies. Muslims have small shops and Karkhana. Some of them also deal in scrap. They all are low-income groups with an average monthly income of not more than Rs.2000.

Alcohol consumption is largely unrelated to occupation. Some adult males in each occupational, caste and religious group drink liquor casually. Their approach towards it is secular, with no myth or cultural significance attached to it, it appears, as a community abstains from it. They have recently migrated and constitute around 10 per cent of the total population of the village. Other religious groups are also of the opinion that the Muslims are teetotalers, but they themselves do not rule out the possibility of a few users amongst them.

Barna village in Rajasthan

Western Rajasthan is one of the most underdeveloped regions of the country. It is a part of the great Thar desert. People are poor and illiterate. Jats and Rajputs are the dominant castes and there is a sizeable Muslim population. The climate is extreme and water is scarce. Households are scattered around, providing little scope for any social life and making provision of health and education services extremely difficult. The major occupations are cultivation and livestock, unskilled manual labour, and handicrafts.

The local inhabitants living in the area for centuries in Rajasthan trace opium use to the Mogul period in the 16th century. It is also believed that people working in the army at that time used opium during the wars. The cultural perception of drug use of the non-Muslims is different from that of the Muslims. Hindu religious traditions do not prohibit drug use whereas Islam specifically prohibits alcohol and by implication all mind altering substances. The Muslims find it difficult to use opium as it attracts greater family and community disapproval than in the other communities. It may be noted that from 1990 to1995, at the NARC Treatment Centre, Bombay, well over 40 per cent of patients admitted for brown sugar addiction were Muslims. However, other treatment centres in Bombay report only a small percentage of their patients from this community. This needs further inquiry. Thus, what is seen in Western Rajasthan cannot be generalized for the entire country.

The legal ban on opium has not affected its availability in the area, though it has resulted in escalating its price. Black marketing has led to deterioration in quality. The custom of manhar and rewan, may have come into being because travelling in the area is very hazardous. Modern communication systems have not made inroads here, and many of the areas are not easily accessible. The difficult terrain, the shortage of water, and heat make travelling in the area a difficult proposition even now.

The discussions with people consuming the drug and people working in a de-addiction centre revealed a number of reasons for opium use, which are mainly related to the hardships of desert life. The excessive heat, the shortage of water and lack of mobility, illiteracy, unemployment and poverty, lack of health facilities etc. have all contributed to creating conditions which promote opium consumption . Traditionally, as mentioned earlier, it is supposed to have been used to help soldiers to cope with the deprivations of war. It was also found helpful in treating people with injuries, particularly those who needed surgery. Opium was then used as a means to cope with physical pain (ODTTRT,1989). In the present circumstances, opium use is attributed to the hard agricultural work in the area. It is believed to help the workers cope with toiling for long hours to eke out a living in the heat and dust. The second use of opium is to help men to increase their sexual prowess. Bridegrooms are given opium on their wedding night.

In some places mothers are reported to give opium to keep their children quiet or to put them to sleep while they are working. Except for one temple in Rajasthan where opium is offered to the goddess, no religious reasons are advanced for its consumption.

A publication of the Opium De-addiction Centre (Afeem Mukti, 1989) in Manaklao identifies two types of drug users –

(I) The regular users, i.e. those using the drug daily, and

(ii) the weekend users, i.e. those who consume the drug for pleasure at weekends.

The following reasons for opium use by youngsters are listed:-

- Peer group influence.
- Use of opium in the family by elders, particularly by the father.
- Teenage tendency to project themselves as adults.
- Parental conflict.
- Curiosity.
- To muster courage to do exceptionally well in some work.
- Seeking release from tensions and
- Easy availability.

The de-addiction centre has conducted a survey of 75 villages to assess the magnitude of opium addiction among the rural population of Jodhpur district. The survey data reveal some interesting facts. An addict is defined as a habitual user who cannot live without opium and never is fully dependent on it. In actual practice, however, the amount of opium consumed by these regular users ranges from 5 grams to 20 grams or more per day.

Out of total of 874 addicts who were studied, only 13 per cent were below 30 years of age; the rest were almost equally distributed among the 30+, 40+ and 50+ age groups. As many as 70 per cent of the addicts were illiterate and 20 per cent were barely literate. Only 9 per cent had completed school education. Nearly 91 per cent of the addicts had an income of less than Rs. 1,000 per month. However, only 11 per cent were unemployed; 97 per cent were male and only 3 per cent female. All of them had been consuming opium regularly for three years or more.

The survey also reported that opium use has a great deal of social approval and it is quite common for anyone to consume opium on different social occasions. It is difficult to find a person in western Rajasthan who has not tasted opium in his life. Ten per cent of the total adult male population and nearly four per cent of the total population are addicted to it. As we have already indicated earlier in the case of ganja, irregular use of the drug does not result in economic disruption. This assertion is supported by the fact that 89 per cent of opium addicts in Rajasthan are employed. However, more in-depth studies need to be conducted to assess the impact of drug use on the work patterns of the users. Though limited, available data suggest that there is hardly any noticeable difference between drug users and non-users as far as their work habits are concerned. No association was noticed between opium addiction and crime or violent behaviour, as is believed in Western countries.

Ganja use.

There are four modes of ganja intake-smoking, drinking in the form of medici-

nal teas and tonics, applying externally as plaster and ointments, and cooking in food. Ganja is smoked in spliffs, or ganja cigarettes containing variable amounts of ganja and tobacco, or in a Chillum. In India, Chillum is more popular in rural and small towns whereas cigarettes are more common in big cities like Delhi. Individual consumption varies considerably from one to twenty chills a day. Other forms of ganja use found in other countries, for example, widespread ganja tea drinking in Jamaica, reputed to have therapeutic and prophylactic properties for specific or general complaints, are not prevalent in India.

A substantial number of occasional or part time vendors distribute ganja both in urban and rural areas. Each vendor establishes his own network of clients, usually a small number of trusted individuals. However, occasionally they may accept clients vouched for by older members. Much ganja buying may take place indirectly through intermediaries. Consequently, the vendors may sell to a small group of people yet they may end up supplying to a large number who buy it through their contacts.

The general belief is that the ganja imported from Nepal is better than that produced in the country. Instances of ganja cultivation were not found in the areas under study, though the plants could be seen growing in the wild in some areas. Places like the 'herb camps' in Jamaica, where ganja is sold along with beer or ale, do not exist in the areas studied. Ganja use in India has generated distinct social groupings. The nature of social groups involved with ganja consumption is influenced by age and work group. There are young smokers and old smokers. Young smokers pick up ganja smoking in the company of friends and smoke ganja during or after work. Ganja smoking early in the day before they start work is fairly common for people engaged in hard unskilled labour. Cycle rickshaw pullers are a distinct category of ganja smokers in eastern Uttar Pradesh

Beliefs and values

Most of us would not consider ganja as having any medicinal properties either prophylactic or therapeutic, unlike opium or bhang to be harmful, as, like tobacco, it affects the lungs. However, the individual users believe that ganja acts as a work stimulant. This tends to support the observation made by Copmitas (1975) in his study of ganja in Jamaica. Comitas questioned the validity of what has been described in the literature as the a motivational syndrome,' or a loss of desire to work, to compete, to face challenges; he also questioned the assumption that the interests and major concerns of the individual users become centred around ganja and the use of the drug becomes compulsive (Smith, 1968). Comitas argued that cannabis in Jamaica, at least on an ideational level, might well be central to a 'motivational syndrome'. Ganja in the rural and also in the urban areas apparently helps the individual to face, start and carry out the most difficult and distasteful manual labour. He argued that in certain types of non-industrial economies, based on small-scale agriculture, faced with difficult ecological conditions, marijuana use might well have a positive social value.

In some situations, 'to smoke' means to conform and 'not to smoke' means social marginality, the reverse of the situation found at the higher social levels. Ganja use in India appears to be a working class occupation, as it is in Jamaica, though here it is legally condemned and publicly denounced by the socially important sections of Indian society.

Not surprisingly, differences in class or sectional attitudes toward ganja are strongly correlated with differences in the prevalence of ganja use between the major social groups. Since in India in the higher social strata ganja use is rare, they look upon its use as a lower class trait. Consequently, ganja use is considered responsible for increase in delinquency and crime rates. The media tend to reinforce these upper class beliefs by highlighting incidents of crime, and the criminals are usually projected as ganja users or alcoholics. These beliefs have further gained currency since ganja use is also predominantly associated with certain nomadic tribal groups. In eastern Uttar Pradesh, ganja use is associated with landless labourers who work on agricultural fields. Since their employment is seasonal in character, some of them are alleged to resort to committing petty thefts for their economic survival

A section of ganja users appears to have internalised these negative views of the dominant society. It is not surprising therefore that even the ganja users themselves are very diffident about its use, more so now, since it has been legally banned. Little, if any, objective and substantiated evidence exists, however, which can support any direct link between ganja use and criminal behaviour. Similarly there is not much difference between the behaviour of smokers and non-smokers with the same lifestyles, particularly their capacity to work and their social relations (Das Gupta,1986). The ganja smoking (rural as well as urban) worker is as law abiding a citizen as any. Nevertheless the stereotypes held and promulgated by the upper class persist in India as they do in Jamaica.

Studies on ganja users in Latin America, particularly Brazil, indicate that the use of cannabis is assigned to the lower class, to people who are unemployed or who are employed in certain specific labour intensive occupations such as canoemen, fishermen and stevedores. Cannabis use in Brazil is also attributed to vagabonds, criminals and prostitutes (Pinho, 1975; Hutchinson, 1975).

In Nepal, the highest as well as the lowest caste use cannabis. One of the most pervasive traditional uses of cannabis in Nepal is not Nepali in character but largely Indian. Because of its traditional association with Shiva, the Himalayas attract many pilgrims from India, including sadhus and other holy men. Many of them use cannabis extensively for a variety of reasons. They use it as an aid to meditation, as was found in the case of ganja smokers in Orissa. Some cannabis users consist of male bhajan (devotional songs) singers at temples. A chillum containing ganja is passed around among the singers. Though it is not obligatory to smoke, smoking signifies devotional fellowship and is said to promote concentration (Fisher, 1975).

Cannabis is used as a medicine. The Ayurvedic and Siddha systems use can-

nabis to treat a variety of ailments in both humans and animals. However, cannabis s never prescribed alone but always in a mixture with other herbs or ingredients. In Nepal a small amount of ganja is used to render children less active.

Cannabis is used by older people of many castes just to while away the time when they are too old to work. Similar practices are found in many parts of India, particularly in eastern Uttar Pradesh, where it is quite common to find people gathering together in the evening or even during the day at the chauphal (the common meeting place) to smoke and tobacco mixed with ganja is also used.

Durgapur, Mayurbhanj, Orissa.

All over Mayurbhanj district the process of modernisation is quite visible and tangible. There are a number of tribal groups, but prominent among them are the Santhals, the Khedyals and the Mankadyas. The Mankadyas are nomadic tribes. There is a cluster of about nine tribal villages (bastis). These bastis are generally inhabited by a single tribal group. For instance, Durgapur is inhabited by the Bhumij caste, Chipadasti by the Sawar,. Raghunathganj by the Bhumjnaik , Bhitiapada by the Tepusai and the Gangraj. Only a few government officers, upper caste Hindus and two Muslim families are migrants; the rest of the population are tribal. The total population of this cluster is around 10,000. Socially and economically they are underdeveloped. This population can be broadly divided into three categories: Santhal (60 per cent), Majis (15 per cent), and Bhumij (25 per cent) with a few migrants. This cluster is situated in a green area, by the side of a river. In its shallow water, men, women and children can be seen washing and bathing. On the other side of the river is a huge stretch of paddy fields. Between the fields and the cluster there is a narrow approach road. Fields by the roadside are punctuated by the bhattis (breweries) of handia, mahua and other illicit liquors.

The houses are spacious and well organised. A complete arrangement is made for the privacy of the members of the family including the guests. Floors and walls are either pucca or semipucca, roofs are generally made of thatch. Both joint as well as extended family systems are prevalent. The average size of a family is six members. Male members have more say than females in day-to-day family life and decision making. They all speak Oriya and Santhali. They can also understand Hindi. The economic activities of the cluster's population are simple.

Santhals gather forest produce, hunt and grow paddy and livestock. They are slowly and gradually drifting towards the lifestyle of the Majis. Majis work in the town as rickshaw pullers, construction labourers and domestic servants. They manage to earn Rs.60 to Rs.70 per day. Higher wages have not improved their social condition. They spend a considerable part of their daily income on consumption of illicit liquor, and it is creating new social problems in the Community. The Bhumij make and distribute handia and sometimes mahua. Among the migrants, some are government servants posted in the area; others are notorious for making illicit liquor.

Handia is the most popular drink in this tribal region. Its preparation is simple and its fermentation quick. One of reasons for its popularity is that it is cheap. People of the area claim that it is not an intoxicating drink but a food which is consumed by every tribal household three times a day. A small amount of it does not produce any mind-altering effect. One liter produces an effect on a casual consumer, but for a habitual one a minimum of two liters is needed to give a gentle kick. The basic ingredients of handia are rice and water. Rice is soaked in water for some time and it is then boiled. After it cools down a herb which is locally called bakhar is added to accelerate the process of fermentation. Bakhar is ground, made into small balls, stored in jars and mixed with rice to make handia when it is needed. Fermented handia naturally splits into three parts. The top layer looks somewhat like water and is called rasi. It is considered the best part. The second layer looks somewhat like separated milk. It has less of a mind-altering effect than rasi. The last part is the rice, which is call Ed pakhal, and it has the least effect. It is eaten.

If anyone in the community commits a mistake which is serious enough to be discussed by the Panchayat, the fine is handia. But the amount of handia does not depend on the severity of the crime.; it is based on the economic status of the offender. Handia also functions as a wage. If an employer does not have cash to pay the wages of labourers working in his paddy fields, he may give them handia instead.

The regular consumption of liquor has made wife and child beating a common practice, never before a part of tribal culture. Synthetic drugs have not yet found entry into community.

There is a section of the Dewar tribe who are rag pickers at Bhilai, a town in Madhya Pradesh known for its steel plant. They pick discarded plastic, coal and a certain amount of amalgamated iron from the vicinity of the plant. The Dewars have a male leader to represent them in all matters concerning the community. He is the decision-maker on behalf of the community and his decisions are acceptable to all, whatever may happen. Their social and economic activities prohibit more than a few families from staying together. Hence, the young married people make a separate group and move away to live somewhere else. They also rear pigs for supplementary income. The average size of a family is seven. They used to consume mahua, bhang, and ganja. A few years ago they used to brew mahua in their homes but now the easy availability of country liquor at low prices has replaced mahua. Each Dewar family consumes an average of two bottles of country liquor, which costs around Rs.12 to Rs.15 per day. They sit down outside their huts on the roadside to drink.

Ganja use in Orissa.

In the border areas of Orissa, West Bengal and Bihar there is a religious movement called the 'baul movement'. This is a 'Sant' movement. They sing songs about Shiva to the accompaniment of a simple musical instrument called 'baul'. In their songs they describe why

Lord Shiva consumes ganja. Their basic philosophy is to get away from materialism. Their activities attract a good audience and create a number of followers of the movement. The basic philosophy of the movement does not seem to encourage the followers to consume ganja as such ; it is consumed rather to achieve a state of altered consciousness. The transcendental state is necessary to escape from 'Maya' i.e. the worldly attachments, or to understand Maya itself. Ganja is therefore seen as a means to go into the transcendent state. The sants convince their audience that there is nothing wrong with ganja as Shiva himself consumed it to attain a transcendental state. Hence, there is no need to feel guilty about its hallucinogenic effect. We visited a Shiva temple in Balasore.

Puri is on the eastern coast in the state of Orissa. This is a non-tribal region and one of the important and sacred Hindu religious and ritual places. It is an ancient city, famous all over the world for the Lord Jagannath temple. The city is also known for its beautiful beaches, bazaars and pandas (priests).

Pandas are generally high caste Brahmins. Most of them own large pieces of land. They either give these to the small farmers on a crop-sharing basis or hire farm labourers to cultivate the lands. The full time occupation of Pandas is helping their clients in different kinds of rituals in and around the temple. They are around the temples and offer themselves as guides-cum-priests to visitors. They do physical exercise, wrestle and drink bhang. There is no distribution or consumption of any drug or drink inside the temple in any form. Outside the temple, however, the distribution and consumption of bhang is very widespread. Respondents indicate that consumption of local drugs other than bhang, e.g. opium and ganja, by elderly women is quite common. Consumption of local drugs is not considered a serious matter and it seems that there are no social codes which condemn it. This is supported by the small bhang stalls which are spread all over the city, and by houses and akhara jagahs (wrestling grounds) where bhang is a causal drink. At the stalls, bhang is readily available in different forms and flavours at different prices without any restriction.

It may be noted here that bhang is also a cannabis compound, as are ganja and charas. All the three contain the same active principle, THC [Tetra-hydrocannabinol]. But the United Nations Single Convention, 1961 explicitly excludes bhang from its purview. India signed this convention in 1964 and the 1985 NDPS Act is based on the Single Convention and is an expression of our fulfilling the national requirement. Accordingly, the NDPS Act also does not outlaw bhang. Thus, even today, selling and consuming bhang are not illegal in India.

At the family level bhang use is an open affair. A father has a fairly good idea that his son takes bhang, but social customs do not permit a son to use it in the presence of his elders, though it is tolerated. There is no class or caste bias in the consumption of bhang. For other drugs, e.g. ganja or modern drugs, the social system does not seem to be so lenient. The consumption of these is not encouraged.

A legend describes how one day the idols of Lord Jagannath disappeared. It is learnt that the idols were seen in the Narendra pokhar (a big square pond in the centre of the city). In order to pull the heavy idols out of the deep water, devotees drank bhang. The idols of Lord Jagannath were thus taken out of the water and reinstated with the help of bhang. This and other such legends support the arguments of devotees who consume bhang, that it is a sacred exercise to enable one to defend the Lord.

It is a general belief that Jagannath still comes to Puri to take a dip in the pond whenever he feels the need. Every year a festival is held at the pond to commemorate the occasion. On this occasion, bhang consumption is considered a sacred ritual. Pandas also defend bhang consumption with the argument that it helps them perform their long, tiring and monotonous work of rituals and worship. In a number of localities in Puri, there are places for wrestling which are also used as youth clubs. Here pandas and other youths do physical exercise. After the exercise they drink bhang mixed with milk and fruits. Many who consume bhang excess however become chronical constipated. We saw some men sit on floor and smoke ganja in between ch fire and sang bhajans. They were 25 40 year of age, working as ricksha pullers, skilled labourers or petty trade Mr. S., a tall and slim 24-year-old Biha migrant rickshaw puller in the city h been smoking ganja for two year According to him, every evening, t rickshaw pullers gather at the temple smoke "Trinath's prasad". Sometim some food is also distributed at th temple by the bhakts (devotees). Eve evening they pool money to buy ganj Sometimes only one or two people spen money to buy prasad. On an average the spend Rs.10-15 per day. According the norms of Shiva bhakti (worship), on one chillum is lit, and this goes arou to all the sitting bhakts. He says that h feels very relieved and relaxed eve evening by coming to the temple an smoking ganja. When he can't go ther he feels very upset. At such times, h says, he does not enjoy pulling th rickshaw at night even if he smok elsewhere. He says that he feels a kin of divine strength after smoking 'prasa at the temple.

Here we have described drug use i one tribal community. According to th 1991 census, the aboriginals are over 7 lakhs and form 22.21 per cent of th population. Generally concentrated i rural areas, about 3.6 lakh of them liv in the urban areas of state.

Kanjipur, Jaunpur district, U.P.

The village Kanjipur is around tw centuries old and is located o Mariyahun in the Jaunpur district o eastern Uttar Pradesh. It is mostl inhabited by the Ahirs and Yadavs, cattl grazers and milk sellers. There is also fair sprinkling of other castes includin the Pasis, Kahars, Kurmis etc. There ar twelve Muslim families. The tota population is around two thousand.

The main economic activity i agriculture, although the geographica and climatic conditions are no

favourable. Yadavs are the more prosperous community in the village. The rest do own some land, but in small amounts and therefore is uneconomical. Remittances from people employed in Mumbai and other places form a sizeable part of the village economy, The village is predominantly illiterate, with only a few people formally educated. There is a proper road leading to the village. Drinking water is obtained from the wells. Some of the families own tractors and motorcycles. Almost all the families have a radio set each. But there are only fourteen television sets in the village. It is mostly a lower caste village. There is not much perceivable friction amongst the various castes.

The consumption of bhang has been prevalent here for a very long time, though it has hitherto been restricted to the festival of Holi. Ganja use seems to have gained currency recently. Around 30 per cent of the young persons above the age of twenty were reported to be consumers of ganja and nearly all young males aged fifteen or more consume alcohol. According to the upa-pradhan (a village leader), members of all castes and religions use ganja, although the Muslims deny this. It is noticed that country liquor, now conveniently available in polythene pouches, is becoming more and more popular. The reasons for this are that it is cheaper and gives a kick instantly; it is also considered upwardly mobile to consume alcohol.

It has been observed that most of the users of ganja are below the poverty line. Ganja consumption does not seem to have an association with any festival or social function. It is not used at the time of marriage or harvesting. It is mostly a leisure time activity. People use it for relaxing or, as they say, " Mooh-bandh banane ke liye " (to shut one's mouth). Ganja use does not seem to prevent people from following their daily routine, particularly their economic disapproval, although its social evaluation is negative. The opinion of Muslims on the use of alcohol is very categorical, namely, that it is not permitted in Islam, whereas for ganja it is ambivalent. They say that there is nothing in Islam which prohibits ganja. They also scoff at the idea of ganja being a tension reliever and have very strong views on its negative effects on health.

Chapter 3

CASE RECORDS.

As part of the data collection, we developed several case records of drug users in different areas of the study and some of these are presented here with a view to understand the relationship between culture and drug use. Efforts were made to include all sections and strata of society. However, the paucity of time and the detailed nature of the information required, have restricted the number of cases. Certain identification data have been modified to protect confidentiality.

Case Record: 1

Name: Mr. V.
Age: 25 years
Religion: Hindu
Caste: Gujar
Native place: Village Dhawlana, Ghaziabad, UP
Length of stay in Delhi: 4 years
Occupation in the village: Kamera (farm labourer)
Current occupation: rickshaw puller
Marital status: married
Income: Rs.100 to Rs.125 pre day
Education: VIII class (failed)
Nature and size of family: nuclear, 3 members

Mr. V. is a cycle rickshaw puller. He operates in the walled city. He is a young man of average height and health. He has his own goods rickshaw cart which fetches him more money than a passenger rickshaw. He transports the goods of a few regular wholesalers in the paper market and earns around Rs. 100 to Rs.125 per day. He lives with his wife (pregnant at the time of data collection) and a two year-old daughter in a paper godown in the market.

He has a joint family in the village comprising of his father, two younger brothers and a sister. He got married four years age. He had been to Delhi several times since his childhood and decided to settle there permanently in 1989. He had come with only the clothes he was wearing and Rs.18 in his pocket. He had a distant relative working in a hotel near Jama Masjid, who introduced him to the manager, who employed him for sweeping and cleaning work in the hotel for Rs.700 per month. He used to eat the left over food, wear discarded clothes and sleep on the footpath near a cinema.

After a few weeks, he was given overtime work at the rate of Rs.3 per hour and was allowed to sleep on the terrace of the hotel. He was able to save Rs.500, and sometimes even more, to remit back to his village every month.

It was in the hotel that he first met drug addicts, gamblers and thieves. He smoked beedis, chewed surti (chuna-tobacoo) and on special occasions like Holi, Diwali or a marriage or birth celebration, he drank country intoxicants like bhang, date tari (a local brew) or sugarcane beer in the village. One day a customer lost some cash and a gold ring and Mr. V. was accused of the theft. He was searched by the general manager of the hotel. He felt very insulted and humiliated and wanted to quit the job. In the meantime, he had developed contacts with a few rickshaw pullers who used to bring customers to the hotel and earned money from the fare as well as commission from the hotel. After sometime he left the hotel job and started pulling a rickshaw which his friend had hired for Rs.12 per day.

Within a month, he met many more rickshaw pullers in the Jama Masjid area. His friendship with them transcended caste and religious bonds. In his social circle, there were many Muslims, Brahmins and Rajputs. He discovered that, barring a few, almost all of his friends were either consuming or peddling drug.

Once he left the hotel job, he had no place to sleep at night and no source of income other than pulling rickshaws, for which he had to depend on the generosity of his friends who, turn by turn, lent him their rickshaws for some time. That was the time when he strongly felt the nee to have his own rickshaw or at least rickshaw he could hire full time on hi own. His social circle was not larg enough and he did not know anyone wh could stand surety for him.

He spent a lot of time with the othe rickshaw pullers. He also tried t participate in their discussions. Most o the time they used to talk about Hind films and charas, ganja and smack. Hi own knowledge was inadequate, so h kept quiet. He felt like an outsider i those groups. Most active participant in the discussions were those who wer experienced in consuming drugs and wh knew the local drug peddlers. They use to dominate the group. These dominan members of his group seem to be the firs role models to inspire him to try drugs The source of their power seemed to li in their knowledge of drugs an conviction in their own world view which they effectively articulated.

Mr. V., who was only a casual beed smoker and drinker of alcohol durin festivals, in a span of two years trie almost all drugs available in Delhi. He however never tried injecting. He share a minimum of two cigarettes of chara and sometimes ganja. The usual time fo him and his friends to have drugs was i the evening, usually after sunset, in park. He also had charas at noon, bu not every day and not in a group. H would have liked to have shared hi cigarette with someone at noon but al his friends were away at that time, an they too smoked it alone, wherever they were.

Mr. V. had not taken drug for any hallucinogenic experience but for the glamour that he perceived was attached to drug use. His attitude towards drug consumption can be attributed to his urge to be recognised as an insider and to become an active member of the group which was necessary for him, especially in the beginning. When he was new in the group, nobody paid attention to him

and at times he was ridiculed by statements like "You do not know anything about the world" , " No one can live in this world being a fool like you" etc.

Action under such circumstances had its own rationale: to know, to talk knowledgeably about the whole range of drugs and some-times even to be able to supply, in order to become an important member of the group. As a matter of fact, Mr. V. said, none of his friends had physically forced him to taste drugs, but their comments had forced him. He said that he could not afford to isolate himself from them for a number of practical reasons; one, he had been earning Rs.40-60 in a day and, after paying for the rickshaw, his food and other indulgences, he was able to save Rs.25 to Rs. 30 per day; two, he wanted to hire a rickshaw on his own for full time and get it duly registered in the Municipal Corporation; three, even if he had hired a registered one, there was a possibility of harassment and extortion by the police; hence he needed some extra income. Such an income was impossible without group support.

It is obvious that such a group, however small, exercises considerable influence on its members' behaviour and psychologically produces a strong sense of belonging and feeling of dependence. It helps in legitimising drug use.

Mr. V. has been in Delhi for almost four years. For the past two years he has been involved in the consumption of different drugs. Now he knows almost all the local places and the people dealing in drugs. He has learnt to get the maximum kick out of a minimum amount of drug. He is familiar with details of detoxification. He said that, apart from intoxication, drugs like charas work as an appetiser but at the same time they, make the user feel dull. In his view, to feel aggressive and potent, one must not take any substance other than liquor,. Liquor is considered a luxury in the circle of drug users irrespective of their social location. Mr. V condemned the glorification and glamorisation of drug abuse. He said that excessive consumption or addiction destroys the addict and his whole family.

Mr. V. spends Rs.15 to Rs 20 on charas and ganja. In the last three or four months, he has reduced his daily drug dose. Earlier he was spending almost half of his daily earnings on drugs. He earns more now and spends less on drugs. This change he attributed to 'society' (He uses the term 'society' for his own small group). Earlier he had to spend more on drugs for others; now he spends less for others and more on himself. He is well aware of the campaign against drug abuse. He says that there was very little truth in what they show on television. He says, "those who have not tried drugs make films and distort reality and those who know about them cannot make a film".

According to his own assessment, his first 'society' in Delhi made it necessary for him to take to drugs but the other 'society' which he wants to move into with his wife, daughter and the unborn baby, looks down upon him and his family. Some people in the market and policemen called him the derogatory terms "charsi" and "ganjeri". He says that he has tried smack and hashish on three or four occasions, but did not get addicted to them. He feels habituated to charas and ganja only. Due to his drug use he is afraid of visiting his old father frequently. His father would feel sad to know about his drug habit. He has managed to persuade his wife not to make any fuss about his drug use. He is however concerned about his younger brothers and his children learning about his drug use and is worried that they too may take to drugs.

Comment

The user does not refer to any religious symbols or social custom to justify his drug use. His statements clearly indicate that in the cosmological construct of his culture, drug use is placed in a negative category. Taking into consideration the fact that he does not use religious symbols either for or against drug use, his lack of education and his non-observance of religious practices, it may be deduced that his 'reference' source was the oral tradition rather than any textual one.

The user's 'performative blueprint' included following: the necessity for him to acquire a position of power in the group; his need for its support; his situational context i.e. his poverty and consequent low status in society, exploitation and condemnation by others around him, the physical pain involved in pulling a rickshaw, sleeping on the footpath, lack of proper food and rest. These became more powerful factors in his immediate present. The negative evaluation by cosmological construct, and the weak control mechanisms (wife's protestations, fear of disapproval of his father and others, and likelihood of children following the same trend), were unable to counter the pressure of the situational context.

Mr. V. can be termed a habituate, but he is not really abusing drugs. His use of drugs is like that of a person who regularly has a drink or two. He has not indicated any health problem on account of his drug use so far, nor has his use of drugs made him economically dysfunctional. An important point to note is that he is not looking for any hallucinogenic experience and he is not willing to switch over to other drugs such as smack in place of ganja or charas. Thus, certain theories of ganja being a gateway drug to heroin need reexamination. The stereotyping of drug addicts one sees in prevention campaigns is perhaps a communication device to simplify messages. But it glosses over the fact that there are different types of drug users.

Case Record: 2

Name: Mr. N. Age: 24 years
Marital status: unmarried
Religion: Sunni Muslim
Caste: Sheikh
Residence: Turkman Gate, Delhi
Education: primary school
Occupation: skilled labourer at a paper envelope factory
Income: Rs.90 to Rs.100 per day.

Mr. N. is a short man with bow legs. On the basis of his self-assessment, he may be called a semi-addict to charas and a casual liquor consumer. He works in a paper envelope workshop being run in a small space (16' x 10') in a narrow lane in the walled city. Ventilation is poor and the place is overcrowded with workers. The owners of the premises, the skilled

labourers and their helpers (apprentices) are all local Muslims who live in the nearby muhallas. Mr. N. works with four other people, whose age ranges from 20 to 35 years. Three of them are each assisted by a young boy. Mr. N. and his colleague, 'M', are also assisted by two boys. These young helpers are in the age group of 9 to 12 years. Only two of them go to school, while most have left without completing the VIII standard. Discontinuation of studies at an early stage of their life is attributed, invariably by all of them, as also the senior karigars (workers), to a total absence of interest in studies.

The envelopes are made with the help of an old iron machine, which is manually operated by a senior worker assisted by a helper. The machine cuts a ream of paper into a specific shape and size with the help of an iron die. Mr. N. says that some karkhanas (factories) have switched over to new technology and have power operated machines. Apart from paper cutting, the whole process of counting, folding, gumming, pasting, binding and packing is carried out by old manual techniques, which require labour and a specific sitting posture. Generally, the right palm of the karigar's hand becomes very hard with regular use of the palm as a hammer to beat and fold a deck of nearly hardened pieces of papers. If the paper is hard he uses a wooden hammer (moghri). The skin of his toes and the right knee also get hardened from long hours of sitting in the same posture. Generally, they avoid the use of any tool because they feel it hampers their efficiency.

There are nearly 80 small and medium envelope karkhanas all over the walled city and some karigars also take work home. The are about 2,000 to 2,500 karigars and young helpers engaged in this small scale sector. They formed a well connected informal network and also have a trade union which functions smoothly. The union has helped in raising wages. By and large, employer/ employee relations in this sector are quite healthy.

The karkhana owners and workers, according to Mr. N., know each other well. Hence, if a worker quits one factory, he gets work at another without any difficulty. But normally a frequent change of workplace is not encouraged by the community. The relationship between a karigar and his helpers (apprentices) is very much like the traditional master craftsman/apprentice relationship.

There is no salary system for karigars. They are paid specific rates per thousand envelopes. If the size of the envelope is bigger and the paper to be used harder, the wages are higher. There is no fixed norm for the helpers' wages which generally depend on their age and skill (speed). They earn between Rs.50 and Rs.150 per week. Helpers receive their payment from their karigar; the owner, i.e. the principle employer, has nothing to do with their wages. He makes the payments to the karigars every Saturday evening. Mr. N. says that workers never have any problem with payments.

A description of social relations and conditions of work is necessary to understand the environment of the community which provides the rationale for the consumption of certain mind-altering substances. Mr. N. disclosed that he and a sizeable number of other workers in the envelope sector in the walled city consume drugs or use liquor. Intoxication is one of the greatest sins according to his religion, Islam. Besides, he says it is socially discouraged. People do not wish to have any relationship and particularly a matrimonial relationship with a drug or alcohol dependent person.

He says that he and other people consume drugs for a variety of reasons, for instance, to overcome fatigue and the drudgery of their routine. Mr. N. started working in the Karkhanas when he was barely ten years old. He smoked his first cigarette at the age of thirteen and has subsequently become addicted to tobacco. Smoking cigarettes is expensive; besides, he has to share his income with his parents. He soon switched to beedis but learnt that a majority of the karigars and many senior helpers consumed drugs. There is wide spread use of charas as it is easily available in the walled city. Recently, other drugs like brown sugar have also appeared on the scene.

Mr. N. has been a regular user of charas for the past seven years. He shares two cigarettes with his friends, one at lunch break and the other after dinner. Sometimes they smoke more than one cigarette after dinner. On weekly holidays they smoke more, though generally they prefer liquor on holidays. His co-workers and other addicts like to consume in groups. He feels that even if a person is miserly and reluctant to share things with others, he is generous and wants to share drugs. (His comment is that man is mean as he shares only poison with other fellow men and never good and healthy things). If there is no one to share his cigarette with, which is rare, Mr. N. smokes alone. Sometimes a friend comes with a charas cigarette while he is working. They go out of the karkhana, take a few puffs and come back to work; this does not affect his efficiency. Mr. N. claims that he has tried almost all types of drugs and alcohol. This might be an exaggeration to impress the investigator. He says he feels calm and relaxed after consuming drugs. He enjoys the self-indulgence for some time. He says that the feeling of well being is so great that one does not want to come out of it. One feels very light, free and master of oneself. It is a kind of feeling which is very different from one which people have when they are 'sober', he says.

He clarifies that, although he would like to remain in that state forever, he does not want to take drugs repeatedly. He elaborates that different people choose different drugs with the sole purpose of experiencing the peculiar feeling. But a particular substance can give this feeling only up to a point. Beyond that a resistance sets in due to certain chemical reactions with in the human body. A drug addict does not want his companions to think that he is 'high'. To remain in control after consumption signifies the proper use of the drug and is hence considered laudable.

As has already been stated, the workers of this sector have been deprived of modern education. They are one of the most marginalised groups in the core of a metropolis. Both culturally and educationally they are at the periphery. They have taken only marginal advantage of being in a big city, the capital of India. In the absence of a conducive

environment, barring a few who can read Urdu newspapers and film magazines for entertainment and information, they depend on television, cable networks, movie theatres, films songs and on their own interpersonal discussions. They do not want to discuss politics because that is 'disallowed by Islam'. Mr. N. declares. The source of their religious knowledge is the few years they spent in a mosque in their early childhood. In madarsa, the religious school, they learnt how to read Arabic so that they could recite the holy text. Mr. N. ran away from his madarsa, as the Maulvi (teacher) was a cruel man, he says.

The respondent views liquor as a luxury. Whenever his financial condition allows it, he goes for good quality liquor, which is more expensive than charas, ganja and heroin/smack. He and his circle do not consume poor quality liquor because of the risk involved. Group alcohol drinkers are different from the ganja smokers. These groups generally get together on special occasions, important festivals or the wedding of a friend. In preparation for such occasions, they start working hard to earn the extra money needed for spending on liquor.

Mr. N expressed a desire to give up his habit of consuming drugs. He appeared very sure of himself and said that he could give it up easily. When questioned about his religion, which forbids the use of drugs, he was unable to defend himself and felt very unsure. He attempted to pass the buck on to his peer group and his work environment. He is not too sure of the consequences of violation of the religious code but has developed a defense mechanism by having faith in the merciful nature of God and the belief that all Muslims will eventually be pardoned and sent to heaven.

However, he was not afraid of exposure, which reflects the lack of pressure of public opinion. Further, since he and his associates do not enjoy any high status in the society, they do not care for public opinion (since society has already formed a poor opinion of them). Further, the inter-group loyalties seem to give rise to a sense of strength and security vis-a-vis outside threats.

Case Record: 3

Name: Ms D.
Age: 38 years
Address: Village Kasti, Tehsil Bhopalgarh, Dist. Jodhpur.
Education: Illiterate
Marital Status: Married (twice)
Religion: Hindu
Caste:Jat
No of children: 2 sons and 1 daughter
Income from all sources: not available
Main occupation: agriculture
Socioeconomic conditions: subsistence existence
Hard drugs and drinks consumed: opium and doda juice
Average expenditure on drugs: Rs.30 to Rs. 40 per day

Ms D. is a tall Jat woman. The investigator met her as one of the 100 opium addicts who had come to attend an opium de-addiction camp. During the camp she used to sit under a tree wearing a colourful ghagra-choli(skirt-blouse); her chunni (veil) would almost cover her face, leaving her chin uncovered in typical Rajasthani style. Generally, the patients formed small groups based on region or language, and spent a lot of time together. Being the only female patient, Ms D. used to sit alone. The investigator was hesitant to approach her but when he met her with one of her male co-patients she turned out to be amazingly cooperative and articulate.

Ms D. said that her first husband had expired when she was 18 years old. He was a farmer and had a good portion of land but was absolutely illiterate. He was a member of a joint family. Ms D. had lived with him for three and half years. She bore him two sons. When her husband died, the first son was one year old, while the second one was yet to be born. At present her two sons are 18 and 16 years old. Her daughter from her second marriage is 11 years old. Her sons are engaged in agricultural activities. They are also uneducated but can read and write simple sentences in Hindi. She sent her daughter to school but she dropped out of the school early.

Five years after her first husband's death, Ms D. was married off to his younger brother (a common custom, especially among the Jats). When the idea was first mooted, Ms D. was slightly hesitant and suspicious but after sometime she accepted the proposal because she was alone and her children were young. Her second husband is an army man. After the death of the first husband, his share of land was equally divided between his two sons; the second husband had his own share. Ms D. says that there was and still is a land dispute within the family itself.

Ms. took amal for the first time a few days after the birth of her second son. In her circumstances, she felt that it helped her to face the multiple problems that she was left with after her husband's death. Other members of the family were hostile to her because of the land dispute. Her economic condition was miserable. She did not have enough to eat. Her second delivery left her totally exhausted, yet she had to work on the fields as there was no one else to help her and she would have lost her land if she remained confined to bed. She began consuming opium to help her carry on working even after the delivery.

Women who had encroached on her fields reminded her that a widow must go back to her parental house, disowning everything which was inherited by her from the husband. When Ms D, made it clear that she had no intention of doing so, a campaign against her was launched, projecting her as 'amaldarni' and 'afeemchan'- a junky. In her village consuming amal was not a socially approved practice, particularly for women. She was the only woman in her village who took amal.

According to Ms D. her main reason for taking opium regularly was the sense of strength and courage ('shamelessness') which it gave her. These helped her work on her fields as well as face all social obstacles. Finally, however, she was excommunicated. Before coming to the camp she had been taking 10 grams of opium mixed with sugar three times a day. She spent Rs.40 on average on amal and tea. She obtained money by selling farm produce and milk and spent all her money on household needs and amal. Her family had no savings. When they had no money she sold off her ornaments

Sometimes Ms. D.'s second husband asked her to give up amal. She did not pay any attention to him as he had not cared for her when she was pregnant. She said that she and her first husband used to enjoy sex though they did not consume opium or any other drug . She does not enjoy sexual intercourse with her second husband, and goes through it only when she is intoxicated. Ms D. got her supply of opium via several hands. She would request other people to get her amal. For six years she had to take doda due to the scarce supply of opium. She puts the opium ball in her throat and pushes it down with tea which, she said, reduces the bitterness of amal to a great extent. She can't leave her bed in the morning without her morning dose in the camp. Ten days without opium in the camp has given her a great amount of confidence; she has not felt the need for opium. She has resolved that she will never take it in future.

Case Record: 4

Name: Mr. B.
Sex & Age: Male ,60 years
Marital status: Unmarried
Native place: ;Barna village, Ajmer
Religion & caste: Hindu
Profession: Tailor
Income: Rs.100/- p.m. as old age pension

Mr. B. is a shabby and unsteady looking man. When the investigator met him first, he was barefoot and wore dirty shorts and a shirt. His hair was unkempt and tangled. His cheeks and eyes were hollow. His eyes had dark circles around them and were watery; his speech was uneven. He could recollect that his parents were darzis (tailors). In the process of helping them, he also learnt the skill of tailoring. He can't say when exactly the process of learning began.

But he is fairly clear about his first encounter with amal. He is also conscious of the gradual process that led to his dependence on the drug. Mr. B. has been taking opium since the age of 10. His father and some other elderly people in the village used to take opium or doda or both. When he was only 40 years old, one of his friends had stolen about five grams of opium from his father. Both he and his friends had always been curious about the dark brown substance which their elders had been so fond of. When he first tasted it, he found it very bitter. After some time, he had felt energetic and healthy and light-headed.

Opium as a Habit:

Consuming stolen opium went on for a few months, sometimes in the company of friends and sometimes alone. In six months, he realized that he had become dependent on it. He had begun to feel a strong need for a dose every day. Soon he needed to increase this dose, feeling that the quantity that he had been taking had stopped producing a trance and the feeling of light-headedness. He started looking for any source, either in the market or from any person who could give him an assured supply of opium without much difficulty. At present he takes 20 grams of opium per day- 10 grams early in the morning and 10 grams in the evening. Half an hour after taking his dose of amal Mr. B. feels energetic and young. If he misses his dose, he has body ache and his eyes become watery. He also loses his appetite.

Earlier, there was more strength in his body, he felt only body ache, but with age and continued use of amal, his mouth and eyes have also started becoming watery. When amal is not available, which is rare, Mr. B. takes doda, which costs Rs.120 per kg and lasts only for two days. Doda is a favourite substitute for amal, as it is seen as slightly more legitimate. When an amaldar meets a stranger, he does not try to conceal his habit of consuming drugs. But Mr. B. does not reveal that he uses opium. In this part of the country, drug use is so widespread and so deep rooted that people do not hesitate to reveal that they use drugs. They do not need to seek any religious or mythological references to legitimise their use. Religious myths are only marginally associated with drugs. People mainly seem to be conscious of the fact that the climatic conditions of this desert area are responsible for drug use, particularly opium. All that an amaldar is bothered about is which drugs a stranger should be told about, so that the stranger does not cause any trouble to them. In such a situation they feel comfortable and safe by telling him/her about doda rather than opium as the 'las' is harsher against opium and more lenient towards doda.

Chaudharis (Jats) are in a majority in Barna. Mr. B. felt that over 50 per cent of males of this caste group consume opium. He says that the per capita consumption of opium by this caste is 40-50 grams per day. Mr. B. and the others believe that due to excessive and regular consumption of amal an amaldar can become 'poisonous'. It is believed that if in the morning an amaldar were to bite anybody, the person would die on the spot. Addicts are always in search of income to ensure a daily supply of opium. Mr. B. says that once he got tired of his work he gave it up, and then did not want to do regular work. Sometimes he supplied milk and sometimes he worked as a domestic servant. He did not worry about where his food come from; he was only worried about his daily opium doses. He said that he never had any stomach ailment. But he has problems, his age being sixty years.

Mr. B. said that he had never missed his opium dose even for a day. He always kept a ready stock. If he ran out of supplies, he got it from other addicts. There were over 300 addicts in his village, so it was not difficult. The addicts never refuse to share their supply with other addicts, which has helped in sustaining their addiction. However, if a person is a habitual amaldar but is unable to buy his supply, such a person is looked down upon and ridiculed by fellow addicts. Amaldars usually gather around a tea shop in the evening. Their evening dose of amal is followed by a round of beedis and tea. In a group, amal is offered to one another with respect.

Mr. B. also confirmed that amal is consumed as a social custom and not as a religious obligation. Among certain castes, like the Jats, use of opium at the time of birth, marriage, death and many other such occasions, is considered sacred. It is mixed with water and distributed among all the guests. The non-consumers are supposed to pay due respect to it and put 'tilak' with it on their forehead. According to him, opium in the village society is not viewed negatively as a social custom, as long as it is a casual affair. But as a habit it is viewed negatively.

Efforts to give up the habit are generally unsuccessful. Those who gave it up, it was found, suffered a relapse within a year. The family responds negatively where a member becomes dependent on opium. Women in particular react to it first. The usual method of control is taunts and calling names and finally withdrawal.

A voluntary organization, Opium De-addiction Treatment, Training and Research Trust (ODTTRT), a pioneer in the field located at Jodhpur, has conducted de-addiction camps since 1979. Over 18,000 opium drinkers have attended these camps. The whole gamut of activities, including social psychology counseling, both on an individual as well as a collective basis, group physical exercises each morning and prayer in the evening are led by the founder director, Padma Bhushan Shri Narayan Singh Manaklao himself. The centre is also equipped with efficient medical staff who provide a twenty-four hour medical emergency cover for the patients. According to the norms of the Trust, in normal conditions medical treatment must be kept to a minimum. Actually, the principle of the Trust is to help the dependant through socio-, psycho- and devotional therapy. (This project is supported by the United Nations Drug Control Programme, Ministry of Welfare, Government of India and the former Maharaja of Jodhpur).

In some pockets of rural areas, mainly eastern, non-arid Rajasthan, one can observe a kind of social process, which has begun to discourage consumption of opium in particular, and other hard drinks and drugs in general. The image of the Manaklao Trust is as a Mecca or a place of confession, and repentance and rehabilitation of an addict. After visiting it, an addict manages to win back trust and credibility for himself from close social groups.

In the above-mentioned pockets, an addict is encouraged by his/her family members to visit and make a 'pilgrimage' to Manaklao (or Afeem Mukti Kendra). When an addict intends to visit it, he gains sympathy not only from his family but also from other village folk. On his return after attending a camp, he gets a positive response from the community.

Case Record: 5

Name: Mr. K.S.
Age: 35 years
Marital status: married
Type of family: joint
Education: standard 3 (failed)
Native place and residence: Balesar Village, Shergarh Jodhpur
Religion: Hindu
Caste: Rajput
Occupation: agriculture
Income: not available, but the family has no problems regarding very basic needs.
Hard drug first taken: opium five years ago.
Main cause of indulgence in drug: Manwar (a reception to guests with opium)
Present intake and expenditure: 5 gms/ day for Rs. 15 to Rs. 20.

Mr. K.S. is a semi-literate, married person. He has a one-year-old daughter. His father has died. His mother and three brothers live with him. One of them is still unmarried. Mr. K.S. is a farmer by occupation. They grow mainly bajra. Apart from income from agricultural activities, the family has a jeep, which is given out on hire, and one of Mr. K.S.'s brother works with a transport company as a driver and earns Rs. 3000 per month. If the monsoon fails, they have to buy food grains from the market. In such times, the earnings from the jeep and his brother's income support the whole family.

Being Rajputs, their women cannot engage themselves in any productive activity. In this part of Rajasthan, the society is still highly stratified. Caste and traditional caste-based customs are strongly structured, firmly believed in and practised. Rajput women still remain within the four walls of their houses. Only male members of the family do outdoor work, including farm labour and grazing cattle.

His wife is an illiterate woman and, being a Rajput , she does not do any outdoor work. Though his village is electrified, he had never seen television before coming to the de-addiction camp. He has been to Haridwar, a religious place and Jodhpur. Women in his family have so far known only a few neighbours and, of course, a doctor and his clinic, but nothing else.

According to Mr. K.S., in his village guests are served with amal galana. It is mixed with water and is bitter. He remembers that during a wedding, half a kilogram of amal was brought in a vessel. Two or three aged persons took the vessel to each of the guests. Each one present partook irrespective of age (when they serve amal on such occasions, as a custom they insist that people take more). Thus, in the village children become familiar with amal (opium) at a very early age. The word amal is a constituent of their early childhood vocabulary.

Mr. K.S. never liked work and studies. He stopped going to school at an early age. He always liked guests coming to his village. Whenever there were guests, he used to spend most of his time with them. Five years ago, for the first time, he tasted amal when it was offered to some visitors. Half an hour later he felt the strength and excitement in his body. His eyes felt heavy and sleepy. He wanted to eat and sleep well, which he did. Four months later, he acquired 10 grams of pure opium from an aged amaldar in the village in exchange for cotton. He consumed only one gram casually. He felt much better than before, with more strength in his body. He wanted to do some work which involved physical labour. This was the beginning of his dependence on the drug. He started taking it regularly. For over four years he has been taking amal in two doses every day, one at 6 a.m. and the other at 4 p.m. He generally consumes it in two forms, either mixed with water or by making a small ball and swallowing it.

After one year, Mr. K.S. began to take three grams in each dose. He also takes doda when opium is not available. He has not only borrowed money but has also stolen to buy opium. In his opinion, one is an addict if one ceases to feel shy about asking for money to buy it. In the beginning he used to feel strength in his body which would excite and invigorate him. He also experiences opium as an effective agent of sexual potency.

There is no trust and respect for an amaldar. Even his close friends and relatives hesitate to lend money to him. Family members keep valuables under lock and key, if there is an amaldar in

the family. On an average, Mr. K.S. spends Rs. 20 per day on opium doses. He takes opium mixed with sugar syrup (chashni). In his village there is a Shiva temple. On every Monday morning, some elderly male folks of the village offer amal mixed with water to Lord Shiva. The same offering is distributed among the devotees as Shiva's prasad. In that ritual many women also participate and a few of them also consume it. His father was also an amaldar.

Mr. K.S. has completed the first lap of the de-addiction process and has been quite successful. He feels that he will get respect when he goes back to his village. His wife had asked him repeatedly to give up amal and he had been postponing this, but finally her persistence has paid off. In his opinion, his addiction would definitely have a negative effect on his family, particularly on the future of his children. He appreciates that they may also be neglected and may not get a proper upbringing if he does not change. His children may also imitate him and get addicted, which he does not want. Another thing which he does not like is his mother buying amal. In his opinion his social system is responsible both for leading him to be dependent on opium and at the same time helping him to give it up.

Case Record: 6

Name: Mr. H.S.
Age: 35 years
Address: Village Shuaria, Jodhpur
Religion, Caste: Hindu, Rajput
Marital status: married
Education: primary school
Occupation: agriculture
Nature and size of family: nuclear; three members- self, wife and two year old daughter.
Annual income: Rs. 5000

Mr. H.S. owns fifty bighas of land which, if it rains, yield ten to twelve quintals of grain. Bajra and jowar are the main crops of this region. Mr. H.S. left school at the age of eight. A naughty and violent child, one day for fear of being punished by his teacher, he ran away from school, never to go back. His father was a soldier in the Indian Army. He too wanted to join the army but he was not selected as he was underweight.

He first took opium unwittingly when he was working in Gujarat. He went with a contractor to work in a cotton mill there. His job was to unload cotton bundles from the trucks and to bring them to machines in the factory. His pay was Rs. 500. He and his fellow workers, who used to work an average of twenty hours a day, soon fell sick. The medical treatment they were given was not very effective. The contractor got worried and one day gave them some strange tasting tea. Much later they learnt it was laced with opium. In less than two hours all of them felt perfectly fit and wanted to go back to work.

According to the contract, the workers were not allowed to go back home for six months. After six months, Mr. H.S. went home. The next day he felt his body aching violently. He felt very sick and developed a temperature followed by loose motion and vomiting. He asked an elderly person of the village for some medicines. He was told that his trouble could not be cured by medicine but by opium. It was then that he discovered that he had been taking opium in his tea five times a day. He did not want to take it again, but the elderly person persuaded him with a promise that if did not recover he would take him to the hospital. He did accordingly and soon felt well. He stayed in his native village for the next two years doing some light work. During that period he continued taking opium twice a day, initially without any health problem. In the beginning it cost him Rs. 50 per 10 grams, which was sufficient for three or four doses, but now it costs Rs. 100 for the same quantity. His recent intake was two and a half grams in the morning and the same amount in the evening. He stopped being conscious of its bitterness and could swallow it without water.

Recently, he decided to give up opium. His mother, wife and some other villagers told him about the Manaklao Centre and advised him to go there immediately. He thought that it would be impossible for him to give it up. He felt as if he was in a deep and dark well and was unable to come out. But after nine days in the camp, on the eve of his discharge, he looked fresh and contented.

Mr. H.S. feels that the promise of sexual prowess is the main cause of the present widespread consumption of opium. He thinks that the Rajputs are the main consumers and the Vaishnavis the main distributors of opium in western Rajasthan.

Case Record: 7

Name: Mr. R.
Caste: Behara
Age: 38 years
Marital status: married
Profession: dairy farming
Native place: Birharekrishnapur (Dist. Puri)
Education: IX class
Monthly income: Rs. 2000

Mr. R. is a slim and dark young man of average height. He seems to be good natured. According to his employer, he is honest and trustworthy. Mr. R. lives and works in a Shasan village which is situated six kilometers north of Puri. The village is famous not only all over Puri but in the whole state of Orissa, as it has produced some very well known personalities. The villagers, irrespective of their caste, feel proud of their small but highly prestigious village. The total population of the whole village is about two thousand. This is a predominantly Brahmin village.

Mr. R. is the only son. His father expired when he was 16 years old. The financial condition of his family was not good. In order to support the family, he had to work and earn some money. He thinks that both his tender age and the peer group which he happened to fall in with after he left his school provided the conditions for him to take local drugs at the age of seventeen. Now he works as a gwala (milkman) and eats a ball of bhang every day with his friends.

When for the first time he had bhang, he felt as if he was floating on air and his whole body was moving up and down on its own. He felt ticklish in the belly and began to laugh madly and was unable to stop. He felt there was something in his stomach which was pulling his tongue inside. He then felt very uneasy and upset and began to create a nuisance. Finally, people gave him some tamarind to swallow. He vomited and then fell asleep. After this experience he firmly decided

ever to take it anymore, but his friends gain succeeded in persuading him to ake bhang. They had advised him to take t in a small quantity and not all of it at a ime, but in stages.

He gradually increased his intake, nd now Mr. R. articulates his xperiences like a veteran! He says that hang enables him to recollect any ncident which has occurred even ten ears ago. He also claims that this appens to almost everybody who takes hang. In his opinion bhang gives a very gentle kick; it is a good appetizer and keeps the stomach cool. He feels his stomach churning when he does not have it. Drinking milk immediately after consuming bhang is considered good, he says. He now not only feels guilt free about taking bhang but also advises others to take it, but with certain timing and precautions. He advises that one should take it in the morning and then eat to feel good for the whole day. In his opinion bhang is a "raja nasha", king of intoxicants. He participates in almost every Jagannath rath yatra and other rituals in which the priests and pandas consume ganja and bhang. He increases the quantity as well as frequency of bhang or ganja intake depending upon his moods. After having bhang, he enjoys playing cards. Mr. R. has tried all locally available drugs and drinks, yet bhang is his favourite drug, since it is a gentle drug and has not made him rude or violent. Mr. R. feels that bhang has not affected his health while ganja does, and is harmful to health. Ganja, according to him, destroys the human body especially the lungs and the liver. He also thinks that it affects the colour of the skin.

Mr. R. says that both bhang and ganja are the prasads of the gods. He believes that these substances are so potent that they enable the gods to think and solve all problems. They enable them to perform miracles and then to forget their kind deeds. According to him, taking drugs, doing great things, forgetting afterwards and recollecting many old incidents are actually the qualities of gods which people can acquire. On the festival of Ponda Sankranti, in his and many other villages of Puri, special food items which contain bhang are made.

Mr. R. takes opium but only as a medicine. Whenever he has loose motions, opium is very effective. Bhang and opium respectively, in his case, work to cure constipation and stop loose motions. He also maintains that these drugs may not suit every one as a medicine and that their effect depends on an individual's body. He says he and many others find it difficult to pass stools if they do not do so immediately after taking bhang. In his village, many old women eat opium habitually as sleeping pills and nobody objects.

Mr. R.'s whole livelihood depends on manual labour. He has to ride a bicycle for 70-80 kilometres every day. Under the intoxication of bhang he does not feel tired. Sharing one of his recent experiences he told of how a few weeks earlier one of his cows had died. His master knew that he would require at least eight people to lift and load the carcass onto a truck. He gave bhang to four labourers including Mr. R. and the big animal was loaded onto the truck without any difficulty.

Mr. R. did not want to disclose the average amount of money he spent on drugs. It seems that a considerable part of his income goes into buying them. Because of economic constraints, they accuse each other of consuming drugs excessively. In his village, almost all males of his caste take bhang or ganja and 80 per cent of the male population of the villages takes one or the other. Women generally take opium. Mr. R. says that he can make bhang himself but he does not have enough time; besides, it is easily available in the area.

Now Mr. R. feels that he should give up drugs but keeps postponing the day when he should start. He has realised, he cannot give up. Despite the earlier glorification of drugs in his 'society', people do not approve of bhang or any other hard drug. Those who imbibe drugs are derogatorily called 'bhangi' or 'nasawala'. The common man adds to his hardships and socio-economic miseries and becomes economically inactive when he begins taking drugs, Mr. R. feels. Some people even sell off their property and articles of daily use to pay for the drugs, he says.

Case record: 8

Name: Mr. C
Area: Puri District, Orissa

Mr. C. is around forty years old; he never went to school. His parents lived in a village and had only a small piece of land. The agricultural income was insufficient to support the family of seven. This had to be supplemented with whatever work various members could get. He was able to become an apprentice at a sweet shop at the age of twelve. It was there that the he learnt the skills of cooking, as well as smoking ganja in the company of other cooks and friends when he was around twenty years old. Smoking ganja seemed to him to be just part of the routine at work. He remembers the ridicule of his colleagues when he took a puff and started coughing as he was not familiar with the art of gradually inhaling the smoke.

He felt somewhat restless and wanted to cling to the group. In the initial period he used to take a few puffs and was not spending any money of his own. As he grew older he started going to other villages on cooking assignments for marriage parties and other functions along with colleagues, he gradually assumed a senior position. By then he was a regular smoker and took the initiative in organising smoking sessions. He also started to spend money for the purpose. The amount gradually increased as the cost of ganja went up, particularly after it was banned in 1985 under the NDPS Act.

Mr. C hardly has any worldview. He has never given any thought to controlling or shaping the events taking place in his life or around him. His self-evaluation was very low. "Ham kya kar sakit hain, saheb?" (What can I possibly do, sir). On the question of his economic condition, all he could say was that it was just a matter of fate. He was born poor and would perhaps die one day without anyone taking note of the event. His children were illiterate like him and were doing nothing. He had no savings but his economic condition has improved marginally as the availability of food has increased somewhat so far as his own family is concerned.

He has not read any religious texts as he was unable to read but he has picked

up some knowledge by listening to others. He was unable to think of any link between religion and drug use. Though he evaluated the use of both ganja and charas in a negative direction, he felt that bhang was more readily accepted by people than ganja. Further, he felt that until such time as you made a fool of yourself by its excessive use, others would not reprimand you, though they certainly look down upon drug users. One chillum pipe was consumed by four to five people in a sitting. He would participate in smoking three to four chillums a day. Excessive smoking throughout the day would mean that consumption could go as high as twenty to thirty chillums. Such excessive smokers were to be found in deserted places in the company of sadhus, sants and fakirs, he says. They are those who have given up worldly affairs. The number of such persons was rather small compared to the general population of drug users.

In his opinion people belonging to all castes smoked ganja and he did not see any link between ganja smoking and his lower caste status, though more people from lower castes and poor people smoked ganja. Mr. C had no idea of how drug use affected relationships in the family. He did not comment upon the sense of responsibility and his attitude towards women. He had not given any though to such issues.

He felt that he could not survive in his profession without drug use. The hardship of his work environment was identified as a reason, as he had to stand close to the fire for hours on end. It was particularly demanding in summers, and long hours made it more tiring. The drug use helped in coping with the drudgery of work. Though he has so far not developed any specific adverse symptoms resulting from his drug use, he did feel it was harmful for health. He has not felt severe pain or uneasiness when he did not smoke although the urge to smoke was there. At times he would make do with some bhang use, either eating or smoking. He felt that more people were turning to bhang as it was cheaper and more easily available than ganja. One puff of ganja could be had by paying one rupee. He knew about 'smack' but felt that its use was not common among villagers and he preferred smoking or using drugs like bhang.

Case Record: 9

Name: Mr. J.
Age: 22 years
Address: Kanjipur village, eastern Uttar Pradesh
Religion: Hindu
Caste: Yadav
Education: 8th class
Current status: unemployed
Marital status: married
Family income: Rs. 2000 p.m.

Mr. J is a young man and currently unemployed. He works on his father's land. His father is in the telephone department. Mr. J started smoking ganja two years ago. He is unable to give any specific reason for smoking it. His version is that some of his friends are ganja smokers and they offered him the chillum. When they sat in a group he would take one or two puffs in the beginning. Gradually he became a regular smoker. He now smokes three of four chillums a day with friends.

Mr. J did not identify any health problems he may have developed on account of his ganja smoking. He feels he is able to work better after taking a few puffs in the field. Nobody else in his family smokes ganja. His father is not very happy with his ganja smoking but he does not get into an argument with him over the matter. Similarly, his wife never discusses the issue with him. He is non-committal about his intentions to give it up. He has no future plans except that he would be happy to get a regular job like his father. Mr. J occasionally consumes alcohol.

Case Record: 10

Name: Mr. N
Age: 45 years
Address: Kanjipur village
Religion: Hindu
Caste: Yadav
Education: graduate
Current status: unemployed (agriculture)
Marital status: married
Family income: not available

Mr. N is one of the few educated persons in the village. He describes his current status as unemployed, though at present he manages his lands and has sufficient income from agriculture to sustain his family. He is married and has four children. He has been smoking ganja for the past twenty years. He shares two or three chillums with people during the day and consumes alcohol regularly.

Mr. N is not very keen on discussing his ganja smoking or alcohol drinking. He feels that these are things which you just do since there is not anything else to do in the villages. He feels that smoking is an age-old activity, indulged in when people sit together in the villages. In some places, depending on availability, ganja is mixed with tobacco. He is not able to give any specific reason for the attraction of ganja except that it gives you a good feeling and helps to while away the time.

Case Record: 11

Name: Mr. B.
Age: 40 years
Address: Kanjipur village
Religion: Muslim
Caste: Nai (Barber)
Education: illiterate
Current occupation: cycle repair shop
Marital status: married
Income: Rs. 500-600 p.m.

Mr. B is a middle aged man of around forty. He is one of the few Muslims who smoke ganja in the area. He has a cycle repair shop by the road side. His shop is a place where people generally stop to gossip. Ganja smoking is part of these gossip sessions, which go on throughout the day. Mr. B is not very conscious of his religion. He is not able to go to pray as he says his work keeps him very dirty. Though he agrees that taking alcohol is forbidden in Islam, he is not very sure about ganja. He feels it is like smoking tobacco. It really did not make him any different. He felt he hardly gets a few puffs out of a chillum as it is shared by many persons.

His family members, particularly his wife, often rebuke him for smoking too much. He has never been approached by a Maulvi saheb (the priest) or any other Muslim in the area to give up ganja smoking. He says he is too small a person for them to worry about. He has been

smoking ganja for the past twenty years. He says that at times it is difficult to get it. He described the ganja coming from Nepal as being superior in quality to the one cultivated locally. He said that earlier ganja was smoked by Kahars (labourers carrying the Palki), since they had to travel long distances carrying heavy loads. He feels that people now smoke ganja just to while away the time or out of boredom. Nobody seems to mind ganja smoking in the community as it does not create any problem. Alcoholism, on the other hand, he thinks, is creating a bigger problem as it makes people different. They misbehave with others and, when they are drunk, beat up their wives. It is also affecting their economic status, because they become lazy and do not work hard in the fields, he feels.

Chapter 4

CONCLUSION

Reflection on case studies

The case studies of cannabis users in eastern Uttar Pradesh, Delhi and Orissa bring out some interesting facts. Invariably, ganja users have started using the drug without getting a chance consciously to think about the decision. Most of them, both in rural and urban areas, were aware of the fact that ganja use was not socially desirable and was harmful to the health. Yet, when they came across the drug at a particular point of time in their lives, this awareness was not able to influence their behaviour. The situational factors of peer group influence or work group influence, the need for identification with the group, the need for protecting their self-image of being 'a man', the need for recognition from the group and to acquire power in the group, and the need to fight fatigue and boredom are more powerful in influencing behaviour.

As Tambiah (1985) has argued, human beings anywhere and everywhere are in their actions simultaneously involved in two modalities: the modality of causality and the modality of performative acts. He pointed out that a classification of a system of categories describes the world, and this description implies evaluations, moral premises and emotional attitudes, translated into taboos, preferences, prescriptions and proscriptions. These are translated into practices. In employing and living them, the actors distinguished by status, gender and expectations, act in a situational context. To quote Kuhn (1968), they are model problems and solutions to the community of practitioners.

The encoding and enactment of classifications or cosmologies as performative blueprints inevitably generate puzzles, anomalies, liminal categories, vacant and fuzzy spaces, which may be regarded as requiring avoidance or as enabling constructions. For example, take the statement of a Muslim charas smoker, who said that it is the state of intoxication which is proscribed by the religious text, not the substances; or another person who feels that alcohol is prohibited, not smoking; and since ganja is smoked, he is not clear about its place in religion. These are typical examples of interpretation of a classification to legitimise its incorporation in the performative acts by taking advantage of the fuzzy spaces.

Further, as Kulckhohn (1954) pointed out, a person's behaviour is not exclusively determined by the whole of his culture. What actually influences a drug addict's behaviour is that selective version of his culture which he internalises as a result of having particular parents, living in one community as opposed to another, being in specific occupations, and all the other objective and subjective forces which by selection and distortion produce his private variant of the generalised culture. Talcott Parsons and others (1953) thus identify three foci of the organization of action: social system, personality and culture.

The data from these case studies seem to confirm this. Both opium use in western Rajasthan and ganja and bhang use in eastern Uttar Pradesh indicate that people, depending on their socio-economic status, locality, educational status, caste and occupational category, interpret drug use and its place in their culture differently. Similarly, different kinds of drugs are categorised and allotted a particular place in the classification, which either promotes or prohibits its use.

The gender factor occupies a significant place too. Most of the case studies bring out the fact that men interpret the use differently from women. However, it is difficult to discern any authentic reason to explain why women in similar conditions interpret the use differently. Why various cultures are more intolerant to drug use by women than men is fairly obvious. Indian culture per se provides little freedom to women compared to men. All religions in India seem to have propagated monogamy for women and various taboos have evolved to ensure that women remain monogamous. The same principal applies when it comes to drug use where such taboos are more strictly enforced in the case of women; women violating the taboos are subjected to greater social disapproval. Lack of economic independence and fear of sexual exploitation, which undermine their social status further, may have kept women away from drug use.

The study clearly authenticates the hypothesis that action placed in the higher disapproval category, particularly seeking its reference from religious texts rather than mythology, makes it difficult for the actors to incorporate it in their performative blueprints. The Muslim community, seeking its disapproval of intoxication from textual sources, has a potential to influence the action of its members generally better than other communities, who are unable to point to such disapproval from textual sources. In western Rajasthan, opium use by Muslims is apparently far less than in other communities. Similarly, in certain areas in eastern Uttar Pradesh, Muslims find it difficult to consume ganja, bhang or alcohol. The religious disapproval can result in stricter community enforcement. The labeling of the actor as an undesirable person, marital discord, displeasure of elders and in some cases excommunication, are some other ways of enforcing the taboo which are reported in this region.

Education and upward mobility in the society also affect the interpretation of drug use. In western Rajasthan it is evident that educated and upwardly mobile youths looks down upon opium use; though it is possible that they may interpret alcohol use differently. Similarly, Brahmins perceive opium use negatively as compared to bhang and alcohol use.

The regional preferences in classification and interpretation of drug use are so interesting to note. Opium use is predominant in western Rajasthan, bhang in Orissa, and ganja and bhang in eastern Uttar Pradesh. Bhang use is more prevalent in rural and small towns of eastern Uttar Pradesh, whereas in Orissa bhang use is more an urban phenomenon. Rural and tribal Orissa and Madhya Pradesh prefer indigenous drinks such as mahua, handia or alcohol, rather than bhang or ganja.

The study indicates that on the whole, persons using ganja, bhang or opium have continued to use the same drug. The habituation to these drugs has not facilitated the use of smack/heroin. Even in cases where addicts were aware of smack, have tried it, and it was available, they have preferred to continue with ganja or opium. This appears to indicate the cultural orientation of drug preference. The type of drug use seems to have a positive linkage with the form (drinking, eating or smoking) of its use. Similarly, the timing and reasons are also culture specific, with opium, bhang and ganja being consumed as part of the daily routine. Further, in rural areas the availability of bhang, ganja and opium is greater. More importantly, ganja and opium users have an understanding whereby they supply the drug to fellow users in times of need. Ganja in particular, being smoked collectively, helps to promote group solidarity which, as the case studies have shown, is an important need of the individual in the low socio-economic stratum.

Economic aspects:

The study indicates that bhang, ganja and opium consumption have not generally rendered the user economically dysfunctional. On the contrary, they seem to have helped in coping with the hardship, monotony and drudgery of the workplace. Opium use in Rajasthan and ganja use in Uttar Pradesh and Delhi clearly confirm this. The chances of upward mobility are almost non-existent in western Rajasthan, Orissa, Madhya Pradesh and Uttar Pradesh for large sections of its population, particularly rural and tribal people. Drug use seems to help in sustaining people's acceptance of and adjustment to such a dismal and monotonous life situation.

It is quite evident that opium consumption in Rajasthan leads to further impoverishment of the poor. The expenditure on opium can easily exhaust the economic resources of a poor person. It is possible that a sizeable amount of income being spent on opium use may lead to less expenditure on other important areas such as education, health and nutrition. Yet these facts do not seem to bother the common opium user since he has no concept of better education or health. As pointed out earlier, a very large percentage is either illiterate or barely able to read and write. Though constant use of opium may create some health problems, their health does not appear to be very different from the non-user in the area.

On the contrary, as the case study of a female addict shows, opium helped her in her pregnancy and post-natal period. She looks at opium as a life saving drug. The study indicates that people are involved in occupations like cattle grazing, which is not very labour intensive. It provides the person with a lot of free time while the cattle wander. Drug use in such situations helps to pass the time or cope with the heat and boredom, and more importantly the lack of a 'tomorrow'.

There are indications that, with possibilities of upward mobility, drug use may undergo a change. The better educated and urban based youth may not accept the traditional forms of drug use, since their lifestyles will be at variance with the predominant life-styles in rural areas. This is evident from the non-acceptance by urban educated persons in Rajasthan of the age-old customs of offering opium at the time of social gatherings.

Managing drug use in a community

The first phase of our project 'Culture and Drugs' was to arrive at an understanding of various factors influencing drug use in a community. In the next phase, the insights obtained were intended to be used in devising culture specific strategies to manage drug use in a community.

Accordingly, for the next phase of the project, some communities have been identified. An attempt has been made subsequently to identify people who could act as community volunteers or activists in managing drug use in their community. The studies of drug use conducted by the Ministry of Welfare in India have identified 'informed person' as a source for information retrieval relating to drug use. Subsequently, in the workshops organised by the National Addiction Research Centre, Bombay, the validity of such information and the definition of 'informed persons' were debated. Therefore, we have made an attempt to identify persons who could be termed as 'informed persons' and to test the scope of their knowledge and its authenticity. The willingness of people to act as volunteers and the training needs of these volunteers for enhancing their skills in performing their role have also been identified.

For this exercise, the Khizrabad area in Delhi was selected. Though use of any kind of drug in the area has not been found to be very significant, the use of alcohol is quite prevalent. The study indicated that shopkeepers, elders settled in the area for a long time and now leading a retired life, doctors, tea stall owners, barbers etc. constitute 'informed persons'. By and large only men were willing to discuss problem relating to the community. They were asked to give details regarding the community, as described below.

Percentage distribution of various religious, regional, occupational and caste groups in the village etc. was one of the indicators. The informed persons were also asked to give detailed information on any other families in respect of number of family members and their sex, age, educational and employment status, income etc. Their knowledge about number of persons in these families using alcohol and drugs or having problems of marital discord, wife beating and so on were also studied.

The population estimates by different people varied from 3,000 to 8,000 persons; the figure mentioned was 5,000-6,000. Similarly, the estimates of distribution of religious groups ranged from70 per cent Hindus and 30 per cent Muslims to 95 per cent Hindus and 5 per cent

Muslims. Our exercise indicates that a majority of the 'informed persons' have been able to give correct or near correct facts. On the whole, people living in the area for a longer time were more accurate.

The number of families whom they knew closely enough for the purpose of being able to provide information varied from three to fifteen, the average number being about five. They knew these families well because of their physical proximity rather than because they were of the same caste or religion. They were unable to give specific information about the educational level of each member but their knowledge about occupation and income was quite accurate. They were also able to identify people using alcohol or drugs in the families. However, their knowledge about incidence of drug use in the community shows a great deal of variation and is vague. Only 60 per cent were willing to give some time to act as community volunteers.

The insights gained from the exercise are useful but more refinement is required. This will be undertaken in the next phase of the project, when more of such areas will be covered and more data about these issues generated. Further, the experience of continued interaction with the communities and informed persons in these areas will throw up more insights. However, all this leads us to conclude that a programme of drug use management with the help of the community is a distinct possibility, which needs to be further explored.

Let us summarise some of the findings, which will help in formulating culture specific strategies for prevention and treatment of drug abuse.

Implications for prevention and treatment strategies for drug abuse:

The incidence of abuse of smack/ heroin does not appear to be very significant in the rural and tribal areas.

The traditional of using bhang, ganja and opium in different areas has not led to use of modern drugs in the rural and tribal areas.

The use of ganja, bhang and opium has varying degrees of social approval in different areas. Ganja is the least socially approved drug of the three in the areas chosen for the study.

Despite the social approval reflected in the nature of the social customs, the use of any drug is generally not consciously encouraged by the family.

The reasons for drug consumption emanate more from the difficult physical and socio-economic conditions prevalent in the area than psychological factors.

The situational context of peer group or work group is more powerful a factor in drug use than any other. The decision to use drugs is seldom consciously taken by the individual. In many cases, drug use is a group activity.

Drug consumption is on the whole not associated with pleasure seeking behaviour.

Community concern about the welfare of individuals is declining even in rural areas. Consequently, community intervention to regulate either community behaviour or group or individual behaviour is also perceptibly declining.

Family relations too are undergoing a change. Parents, even in middle class families, are becoming less communicative with grown up children.

Poor families in rural areas generally do not have close and intimate relationships either between spouses or between parents and children. It is a working kind of relationship. Communication is very nominal.

Women have very little authority in the household. Their sense of the desirable or undesirable is based on oral traditions. Their classificatory scheme is also rooted in oral traditions. They are unable to exert sufficient influence over their spouse or children, although the job of socialisation of the children is entirely left to them.

Cultural norms relating to drug use are more strictly enforced in the case of women.

Cultural orientations of people towards drug use, type and form undergo a change with upward mobility, education and change of location.

The lack of opportunities for upward mobility for the present or the future generation may induce a sense of apathy, which acts against the cultural norms regarding drug use.

Cultural orientations rooted in religious texts have greater potential for influencing drug use.

Cultural taboos are likely to be more strictly enforced in communities experiencing cultural isolation or fearing a loss of cultural identity in multicultural societies.

Macro changes in the economic, legal and social environment of a society will in turn affect the micro-cultural traditions.

The individual's cultural perceptions of drug use will depend on the individual's socioeconomic and spatial status.

Perceptions of drug use, type and form are also influenced by caste affiliations.

Drug use is generally considered harmful for health.

Any evidence of drug use and criminal behaviour is not easily discernible from the available data, though there is a general belief among the addiction professionals that drug use promotes criminal behaviour.

The knowledge of 'informed persons' in the urban area is not very authentic.

The span of knowledge about neighbours does not go beyond two or three houses in urban slums.

On an average, a community volunteer is willing to give 1-2 hours a week.

Young males take more interest in voluntary work than females and adults.

Training may improve the knowledge of the community volunteer about drug use.

Community volunteers could be used for monitoring the drug use in a given area.

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MONOGRAPH 2

CULTURE AND DRUG ABUSE IN GUJRAT

Dr. Edwin J. Masihi
And
D.B. Desai

Chapter 1

CONTENTS AND METHODOLOGY

Studies in India regarding drug abuse have concentrated on individual victims. They try to ascertain the characteristics of such individuals - their age, education, occupation, social class or caste, etc; the age at which the drug was first consumed, the company in which it was taken, how the addict was introduced to it or his first experience of the drug, etc. (For an annotated bibliography of drug abuse research in India upto the year 1985, see NIPCCD, 1987).

The estimation of prevalence rates has occupied an important place in the field of drug abuse research. The urban elite stipulates premise and assumes that drug abuse is a deviant activity and as such is a criminal act. Drug users' behaviour is alienated behaviour and the use of drugs is not considered a legitimate, prestige giving or status enhancing behaviour. But when the larger context of culture is considered, probably we have to revise our views. The relationship between culture and drugs is a relatively unexplored field of research and few attempts have been made in this direction. Ours is one such attempt. The drug studied in this research was opium as perceived in its cultural context. The western region of Gujarat State, known as Saurashtra, is the locale of this study. In the next chapter the historical condition and the economic and political structure of the region are described. It is through these that the cultural ethos of the region evolved. In this study an attempt has been made to depict how opium has become part of the cultural life and how it is reflected and thus interwoven in the cultural system of the region. There is no single methodology, which can cover the phenomenon in its totality; hence an approach is needed to gain a holistic picture by using various methods available in social sciences. We have adopted historical and empirical methods and they generate quantitative and qualitative descriptive data.

To get acquainted with opium use in this cultural region, the researches employed the following strategies:

First, it was decided to see the actual way of preparing and consuming opium liquid (popularly known as 'Kasumba Pani' in local parlance). For this, the researchers contacted a habitual user through a confidante. Through this user, his whole group was contacted. The researchers went to his residence. The user, who was a retired wealthy farmer, demonstrated in his friends' company, the method of preparing 'Kasumba' - the materials, the technique of preparation, the tools used, such as mortar (kharal), strainer, stand, small serving bowl and the local variety of pipe-smoking with its tobacco. This was followed by an informal talk about opium, its sources, purity etc.

The second strategy was to meet the people who were familiar with the culture and society of Saurashtra. They included sociologists, historians, folk artists and others. Seventeen such knowledgeable people participated in the meeting. They were asked to give details about opium use, its description in literature, its impact on the opium users, women and other sections of society, its proscription by the saints of the region, beliefs and attitudes towards opium consumption and the role of the bard-caste in a 'dayro' (opium drinking gathering). This meeting gave insights into the use of opium and its cultural manifestations. It was very useful in the construction of the interview schedules.

The third strategy was to collect secondary data from various sources. For this purpose many historical documents were examined. We also asked some scholars to prepare notes on opium

(1) from the viewpoint of Ayurveda,

(2) opium as described in the Charani literature,

(3) works of some well known Gujarati writers of this region and

(4) the saints of Saurashtra and their preaching against opium.

These notes/writings indicated the complexities and inter-connectedness of opium in a wider cultural matrix.

In this study, survey research was also employed. The researchers decided to study two villages from each of the six districts (Junagadh, Bhavnagar, S'nagar, Rajkot, Amreli and Jamnagar) of this region. Each district has more than one hundred villages and in every village opium drinking is common. So selecting the villages was a difficult task. It was also difficult to know which villages would have larger numbers of opium users. So we met people who could give us the names of such villages. One source was the religious leader of a dominant caste, who suggested the names of certain villages. Similarly, we identified a few other villages with the help of some other persons. Thus, we were able to get the names of some twenty-seven villages reported to have a high concentration of opium users. The selection of villages was purposive.

The field investigators were chosen from the same region so that they could

understand the local culture and language. Preference was given to investigators from the dominant castes of the region. The field investigators were all students of Saurashtra University (Rajkot), who had passed their M.A. examination in subjects like sociology and economics. They were thus familiar with the techniques of data collection in a social science research. However, before they wee sent to collect data, the researchers gave them one day's training, thereby acquainting them with the interview schedule and the objectives of the research. They were also provided with a detailed note indicating various points to be borne in mind while collecting information. Periodic supervision of the field investigators was carried out in order to ensure reliability of the information collected. Since opium use has become an illegal activity since September 1985, we were concerned lest users might be reluctant to give information about their habit. But as the investigators were from the same region and from a high caste, data collection was carried out with relative ease and promptness.

An interview schedule was administered to 158 respondents from the 12 villages of the six districts. The respondents were also selected arbitrarily, depending upon their willingness and accessibility. The number of respondents from every village was not fixed; it varied from village to village ranging from six as the minimum to 18 as the maximum. Data were then coded, analysed and tabulated. About 77 per cent of the interviews were held in private places and 20 per cent were carried out in public places. Since a large number of the respondents were from the dominant castes and were landowners, the classification adopted here is not as per the standard national definition of a 'small' farmer.

Along with the primary data of twelve villages, we were able to obtain secondary information on 458 opium addicts from this region from a de-addiction centre. The information was limited to a few socio-economic variables like age, sex, education, religion, caste etc. These data were also analysed and used to supplement the picture emerging from the primary data.

Thus, the researchers have tried to study the pattern of opium consumption in its cultural setting and how it was once a part of the daily life of the people. As it is a part of the cultural tradition, various methods and approaches were used to see the relationship between culture and the use of opium.

Chapter 2

CULTURE AND OPIUM USE IN SAURASHTRA

Saurashtra: the locale of the study

The region of Saurashtra forms a part of Gujarat, one of the states of India, which is highly urbanised and industrialised. The term Saurashtra is a corrupt form of the term 'Su Rastra' or 'good state'. The region was also known as Sorath or Kathiawad, though both denote different sub-regions of Saurashtra.

Saurashtra is spread over an area of 64,338 sq. kms. To its South and West lies the Arabian Sea, to the North, the Gulf of Kutch and Rann of Kutch, and to the East, the Gulf of Cambay and the Mehsana and Ahmedabad districts of the Gujarat state. Bounded by the sea and a desert on its three sides and situated in the interior part of Gujarat, the region is geographically protected on almost all sides. However, races and groups of people belonging to various ethnic backgrounds have found shelter in this region. The landmass includes hills, forests, desert and plains as well as riverine areas. The hills and forests provided good hiding places for those groups, which were fighting against the various established political powers, like the native states or the British government.

Climatically, Saurashtra is a semi-arid region. The rivers are not perennial and the average rainfall of 51 cms is not sufficient for a good harvest. The climate is dry, with extreme heat in summer and extreme cold in winter. But the region is rich in some minerals.

Historically, Saurashtra was known as an independent entity and it finds a mention in the Mahabharat. The area was never under any single ruler since it is away from the main seat of power at both Delhi and Gujrat. A number of kings and princes established independent or autonomous territories. In the absence of a single political authority powerful enough to control the various small and constantly warring kings and princes, the area was in a perpetual state of conflict, with each group trying to expand its influence and merge the neighbouring territories into its fold. The Muslim influence was felt as early as 1024 AD. The Marathas did not conquer and rule Saurashtra but established their authority in the region to collect tributes from the local chieftains. It was only during the British rule that some semblance of order was established in Saurashtra.

When the British entered the scene, Saurashtra was ruled by many big and small kings and chieftains. These rulers had given some of their villages to their relatives, nobles and warriors in recognition of services rendered or loyalty shown. The British guaranteed the rights of all these states and territories and divided them into various categories.

Pre-British Saurashtra was divided into 10 regions, viz. Zalawad, Machhu-Kantha, Halar, Okhamandal, Barda, Sorath, Babriawad, Gohilwad, Undasarvaiya and Kathiawad. Rajputs, Kathis, Marathas, Muslims and Portuguese had authority over various parts of the region but the majority of the rulers were Rajputs belonging to various clans, such as the Zala, Jadeja, Jam, Jethva and Gohil.

During the British rule, the ten regions were grouped into six districts. They were renamed after independence as Amreli, Bhavnagar, Jamnagar, Junagadh, Rajkot and Surendranagar. Demographic data shows that the scheduled caste population is large and those from scheduled tribes are very few in number.

Cultural characteristics of Saurashtra

Saurashtra has a distinctive lifestyle. The Gujarati language is spoken by a large majority but the way it is spoken here sets the region apart from the other parts of Gujrat. There is also the 'Raas' dance wherein men and women briskly move in a circle and play with two small wooden sticks known as 'Dandias' in their hands, which is unique to Saurashtra.

The Charans, a bard-caste, compose verses called 'Duhas'. The Duhas are often instantly composed. The language is rhythmic and the bard usually sings them aloud, at the end of which the audience expresses its appreciation through exclamations like 'wah-wah!'(which means 'well done!'). Duhas are sung when people assemble in groups, usually at the residence of kings, princes or chieftains. The dress and ornaments of the people of Saurashtra hold significant contrasts to those of the other regions of Gujarat. This region has a variety of castes, communities and religious sects. In spite of living side by side, most of these groups have maintained a measure of distinctiveness. This is because of the conservative nature of the people. Although Gujarat itself is a conservative state, Saurashtra is more conservative than the rest of Gujarat. However, some cases of inter-caste marriages among the Rajput-Kathri castes are reported. The Hindu-Muslim cooperation and interdependence are also noteworthy. A story where a Hindu prince tried to protect the chastity of a Muslim girl who was being followed by a Muslim king illustrates such cooperation and mutual respect. The stories by the famous Gujarati novelist Zaverchand Meghani (1946) provide enough evidence of such interdependence.

A set of three volumes describes seventy-five castes/communities of Saurashtra (Saurashtra Backward Class Board, 1957, 58, 59). The striking feature of these castes/communities is that a majority of them have surnames used by the Rajputs and claim the lineage of Rajput castes. Many of these castes/tribes are of an aggressive nature and have indulged in plundering, piracy, extortion, dacoity and such other activities.

This in a way entitled them to claim the Rajput affiliation.

Unlike other parts of Gujarat, where the dominant elite groups were and are Bania (a trading caste) and Brahmins (a priestly caste), in Saurashtra it is the Rajput and Kathi castes who occupy this position. It is not possible to give details of the clan differences found among these Rajput and Kathi castes. Suffice it to say that there are many groups among them, like Parmar, Gohil, Jadeja, Jethva, Khacher, Wala, Khuman etc. All of them claim to have descended from some mythical supernatural entity. History is so closely inter linked with myths that it is difficult to say how these various groups have come to live here but, because of their political dominance in this region, they have become the norm setting group. As M.N. Srinivas writes in connection with 'Sanskritisation' (Srinivas, 1978), there are various models which people imitate in different regions. In Saurashtra it is the Kshatriya or Rajput model, which is being followed by most of the castes. Brahmin and Bania models are the exceptions.

Saurashtra society is perceived as consisting of various strata. The upper castes, consisting of Brahmins and Banias, are labeled as 'Ujali Varan' or 'the fair coloured ones'. The Rajputs and other warring, aggressive communities are known by the term 'Kantiu Varan' i.e. 'the dark complexioned ones'. These generally are abrasive and high handed in their behaviour. The lower groups are divided into two categories, viz. 'Vasvaya' (those who were allowed to settle in this region: they include all the artisan castes like blacksmiths, goldsmiths, carpenters and others) and 'Lok Varan' (i.e. common, unimportant people).

The absence of the Brahmin and Bania castes as a dominant group is responsible for the rise and spread of local type Hinduism, or the 'Little Tradition', as against Sanskrit Hinduism, or the 'Great Tradition'. As part of the local level Hinduism, we find numerous Gods and Goddesses as well as saints and religious leaders in this region. Zaverchand Meghani, who tried to bring out the essential characteristics of the regional culture of Saurashtra, mentions the names of ten such local level saints, out of whom three were Kothis (a dominant caste), one a Rajput (also a dominant caste), one a Lohana (a high caste Hindu), two Chamars (cobblers), one Koli (a tribal group) and two Muslims. These saints were a great force trying to ease the rigidities of the system.

The lack of a powerful Sanskrit tradition has given rise to the caste of Charans (also known as Barots or Gadhvis) who are known as Deviputras (sons of the Goddess). The Brahmins, on the other hand, are known as Bhudevas (Gods on earth). The Charans perform many of the functions in Saurashtra, which are performed by the Brahmins elsewhere. It is considered a great sin to hurt or kill a Charan, as it is to hurt or kill a Brahmin. Because of this institutionalised and religiously sanctioned protection, the Charans could fearlessly admonish or advise the rulers, however bitter it might appear to the latter.

The numerous big and small states into which Saurashtra was divided also gave rise to a feudal type of land tenure. All agricultural land belonged to the rulers. They in turn gave it to their relatives or other loyal servants who might have rendered useful services to them. There were many types of land tenures. It is not necessary to go into the details of this complicated system. It is important to mention that the system created landlords who owned land but did not cultivate it or encourage the peasants to work with any measure of commitment.

The system also gave rise to a class of landlords who were closely related to the political rulers and had enough leisure and money to spend. The non-involvement of the feudal class in any gainful economic activities and the consequent leisure available to them made 'easy-going life' a value to be imitated. There was enough time and no hurry. So if one is invited to a marriage feast, till the host sends calls three or four times, the guests do not go. In the case of the marriage of a Kathi girl, the bride has to circle the sacred fire seven times, but she puts one step forward only when her girl friends physically lift her foot and put it forward. Often the whole night would be spent in completing the seven rounds.

The system instilled paternalistic values among rulers towards their subjects. The peasants used to accept the rulers/landlords as their protectors and, in turn, showed their loyalty and devotion towards them. In the not-too-distant past, where internecine wars were very common, values like loyalty and devotion were essential for the survival of the social system. When the princes and their queens has to flee their palaces, leaving their offspring with their servants, the latter used to look after the young prince/princess at the cost of their lives and often managed to recover power for them. Such servants usually belonged to a caste called Khawas.

The exploitative nature of the feudal system created many outlaws. Those who felt that injustice was done to them, used to turn against the established rulers and proclaim themselves dacoits (bandits). In local parlance such people who rose against the political authority of the local prince/king were called 'Baharvatio', which means one who follows the outside (bahar) path (vat). They plundered villages and forced the rulers to render justice. The region has seen many such outlaws who were otherwise men of high values and virtues. Meghani, who has glorified and immortalised many of these dacoits, describes them as brave, honest, truthful, noble, altruistic and ascetic. It is said that one dacoit was so concerned about small insects that he would not allow the worms in his wounds to drop off, and in case one did fall, he would himself put it back in his body, notwithstanding the pain it would cause him.

Opium as a drug found very fertile soil here. It forms part of the lifestyle of various segments of the Saurashtra society. It was available liberally and was used extensively. As opium was an expensive commodity, it was considered the food of the royal classes. In the local language, opium was called 'Amal', which means 'rule or 'control'.

There are two ways in which opium was and is consumed. One is the popular upper caste method of consuming it in a liquid form.

In this method, opium is cut into small pieces and then it is ground or made into a paste with the help of a small wooden

pestle in a slightly shallow stone (mortar). The wooden pestle is made of a particular tree called Kerada which itself is supposed to be a good cure for various types of ailments. Water is added to this paste along with other spices such as saffron, cardamom etc. The liquid is then filtered several times through a thin cloth. Ultimately, when the required saffron (Kasumba) colour is reached, the liquid is given either in small metal vessels or cupped in the palm of the hand. In the past it was usually at the residence of the prince or chieftain that opium service sessions, or 'dayros', were held. The type of vessels used to serve opium liquid reflected the socio-economic status of the host. It was the host who usually paid for the opium.

Dayro sessions were usually attended by men belonging to the same or similar status. Women did not form part of such gatherings. There were other attendants, like a barber, a Charan or a servant of the host. The barber or the servant prepared the liquid and served it to the assembly. The Charan regaled the gathering with his verses (duhas). The verses contained praise for the host or his ancestors or some warriors past or present. The Charan was rewarded by the host for his verses of praise. Sometimes, when the Charan did not praise the host or his family, the latter got annoyed but the Charan was not punished for his behaviour, as he was a 'deviputra'. Participants of a dayro cannot refuse 'Kasumba Pani', as refusal would be tantamount to an insult to the host. When opium liquid was served from the cupped palm, the person to whom it was given allowed some liquid to flow out with the help of his finger so that he did not get an overdose of it. In such a gathering the host urged the guests to take more of this liquid as a part of the tradition, and often several rounds were served. The Kasumba Pani was often followed by tea and snacks.

Since the dayro continued for many hours, only those who had no work and enough leisure were in a position to take part in it. Naturally, it was consistent with the feudal system, where the landlords were free from all the bother of economic activities. But such a manner of consuming opium was not consistent with the lifestyle of those who were engaged in day-long labour activities. Such persons took some granules of opium and chewed them. This was called 'rogu'. It was the usual way in which manual castes enjoyed opium.

Battles and opium consumption

In the past, several conditions provided an environment conducive to opium consumption. There were frequent wars and battles. The region had many big and small states constantly at war with each other. Members of the Rajput and Kathi castes had to go to war very often. They consumed opium because it served as a pain-killer for the wounds, which they sustained. Moreover, these warriors were able to restrict their natural processes and continue to fight with the help of opium. Opium also gave them strength to fight with increased vigour. However, it was also necessary for them to take rich food with opium, which largely negated the negative effects of opium.

Opium and potency

It was also believed that opium had the capacity to increase the sexual potency of the consumer. The Rajput Kathi rulers and warriors were free to marry more than one woman. Many of the kings and chiefs maintained large harems and in order to enjoy sex they consumed opium. Many of them married young girls even when they themselves were old. Such persons consumed opium in order to regain their vigour. However, the effect of opium consumption was contrary to what was expected. Such persons became lethargic and inactive instead of vigorous and active.

Opium and diseases

People relied on opium when they suffered from some painful or incurable disease. As a pain-killer, opium provided good relief in the absence of any other cure.

Opium as a protection for the future king

Formerly, when the kings or chiefs married many women, there were frequent conspiracies among the queens to make their sons inherit the throne of their father. In such a situation, a rival queen might plot to kill the heir apparent. In order to protect her son, the chief queen used to give her son opium so that he became immune to any poisonous food offered to him. Thus opium was part of the socialisation process and mothers gave it to their sons deliberately.

Opium and the enemy

Opium was used to cement friendship bond. It was used as a mark of close friendship. At a time when restrictions on food and drink were very severe and caste rules did not allow a man to accept food or water from the members of lower castes, sharing of opium liquid was a mark of friendship and trust. This gesture converted enemies into friends; thus opium was used to celebrate such events. Conversely, opium was also used to ruin an enemy. It was considered the safest method of defeating one's opponent.

The status of a Bandhani

Since opium consumption was an accepted behaviour it was accorded high status. One who was able to consume large quantities of opium was respected. Since opium was costly, only the rich could afford it. Therefore consumption of opium in large quantities and high status were directly related. Unlike an alcoholic, who behaves in an unbecoming fashion, an opium addict becomes passive and does not manifest any gesture, which might invite censure. On the contrary, his passivity gives an outward appearance of a wise and thinking person. An opium addict was described as a 'Bandhani', (literally meaning one who regularly consumes opium). The term was an honorific title, giving prestige and status to the man. Whenever it was said that 'so and so is a Bandhani', it meant that he was a respected man. His advice was sought on important matters and people came to him to discuss their problems. Bandhanis were supposed to be very generous in their behaviour. They would not tolerate any lack of discipline.

On the other hand, some opium addicts were also described as people who had no self-respect because, if they did not get their quota of opium, they would not hesitate to get it from their inferiors

r dependants. When they were under
e influence of opium, they acted in a
lly manner. They were also described
s timid and suspicious.

Thus, folklore portrayed a dual im-
ge of opium - of use and abuse - and
howed that social acceptability was
ased on the behaviour of the user. It
ppears that the society's focus was not
n quantity of intake. These aspects need
urther exploration.

Opium as a way of escape

In extreme cases, when people
vanted to get away from any painful situ-
ation, they took an overdose of opium to
nd their lives. Women often resorted
o it in cases of domestic discord.

Opium in literature

Since opium was associated with warriors and the ruling Rajput/Kathi castes, it was glorified in the oral (charni) literature. At the same time, there was another version in the literature wherein the negative side of opium was highlighted. However, the trend glorifying opium has remained more powerful than the latter one.

The Bard-castes, known as Charans, Barots or Gadhvis, were a common sight at the courts of various native princes. These princes held courts in which opium was served. The Charans praised the princes and their various behavioural manifestations. One such behaviour was opium consumption and the Charans have used all their literary skills to glorify this drug. It is difficult to describe at length the various facets of this literature dealing with opium, hence only a few illustrations are given. The term opium has many names in the Charni dialect. It is called amal, kasumbo, afu, tijori, galva and kanki.

The origin of opium is linked with the Hindu mythology of gods and demons churning the ocean with the help of the cobra to gather nectar from it. The foam of the cobra was the original opium. The liquid is compared with buffalo milk. It is said that if a small drop of opium falls on the ground, it divides the earth and goes to the bottom, where the cobra ('Sheshnag', who is supposed to support the earth on its head) resides, and shatters its head. If the liquid is drunk by the father, his son gets the effect; if a horseman drinks it, the horse gets the effect; if an elephant drinks it, he becomes wild; if a cat tastes it, she can kill a tiger, and likewise a donkey can kill an elephant, a dog can kill a lion and a sparrow can kill an eagle - so say the poets.

Elsewhere, opium is described as a companion of the traveler, a friend of the brave, and fire for the enemy. It makes an impotent man potent. It is solace to the gloomy and a cure for the diseased. But there were local saints of the Bhakti (devotion) cult, as well as religious leaders of the Swaminarayan sect, who preached against the use of opium. After pointing out various negative consequence of opium addiction, they said that the intoxication of opium is only temporary, whereas the intoxication derived from the devotion to God is permanent. The Swaminarayan sect was founded by Sahjanand Swami (1781-1830), whose real name was Ghanshyam Hariprasad Pande. He worked among the lower caste Hindus and made them give up alcohol, tobacco, opium and such other drugs. The sect is part of the wider Bhakti movement, which was started in the Middle Ages, mainly against the intellectual tradition of Hinduism and emphasised worship of God through simple behaviours, like singing devotional songs, observing fasts, giving alms, taking baths in the holy rivers and visiting pilgrim centres. The devotee assumes that God is the master and the devotee his servant. In extreme cases, the relationship is one of husband and wife. In a traditional Hindu family a wife is required to be completely devoted to her husband (Pativrata). So when a devotee surrenders to his/her personal God, s/he visualises himself/herself as a wife and his/her God as his/her husband.

Recent changes

The situation changed drastically after India became independent. All the Princely States were integrated into the Indian Union. This took away the political authority and economic power enjoyed by the former kings and native princes. Their courts came to an end. The Charans no longer had the opportunity to praise the virtues of opium.

The land reforms initiated by the government altered the feudal order, thus bringing about another significant change in the cultural life of Saurashtra. The law attempted to make tenants the owners of the land they cultivated. Thus, some of the landlords lost their leisure and were forced to take up some economic activity to sustain themselves. Caste played an important role in the differential benefits that accrued or did not accrue to tenants.

Although these changes were introduced more than forty years ago, the dominance of the Rajput/Kathi castes has continued. Electoral politics have contributed to altering the balance of power between various caste groups. In particular, the tenants belonging to the Patidar caste (a peasant caste), became dominant as a result of economic changes and the political process based on elections. The rivalry between the Rajput/Kathis and the Patidars has increased over the past few years. As a consequence, caste violence in the countryside often occurs during elections.

The Narcotics Drugs and Psychotropic Substances Act, 1985 (NDPS Act) banned the use and the sale of narcotic drugs. This led to the criminalisation of opium consumption and thereby undermined the legitimacy and respectability enjoyed by it. It also made an elitist behaviour a deviant one. With that, opium has gradually become part of the wider criminal set-up. Though consumption of opium has not altogether stopped, there is a distinct change in the behaviour of addicts. Gone is the high status of a Bandhani. Now people do not want others to know that they consume opium. They do not allow strangers to visit the place where they consume opium. In one case where we visited some opium addicts, we found that even the boy who brought tea for us was not allowed inside the room.

In this changed situation, how people continue to consume opium will be seen in the next chapter.

Chapter 3

OBSERVATIONS BASED ON FIELD DATA

By criminalising the cultivation, sale and consumption of any narcotic drug, the NDPS Act overnight outlawed a behaviour, which had hitherto been considered prestigious and respectable.

In order to understand opium consuming behaviour in this changed situation, primary information from 158 opium users from twelve villages of the six districts of Saurashtra was gathered. The following discussion is based on the interview data of these 158 opium users.

The twelve villages were selected on the basis of information gathered from experts who reported that large numbers of opium users were to be found in these villages. Field investigators obtained the names of the opium users from the villages and interviewed those who usually consumed opium in a group, although occasionally they did interview those who consumed it alone at home. In the groups, not all the addicts were interviewed, for want of time. The interviews were usually held at the respondent's residence (77 per cent) but also outside, on the farms, or at the Panchayat office etc. The names of the villages, the talukas and the districts of which they form part, are given in the tables. That only a few interviews were canvassed from some villages does not mean that the villages had only a few opium addicts. It must be put down to a failure on the part of the investigators.

The 158 opium users were overwhelmingly males, with only two females. As per the sample mean age of the user is 56 years, around 53% belonged to the age group of 56 years and above and 44% between 36 and 55 years. It is generally observed that opium users come from the older age group and, as a counselor attached to a de-addiction centre once candidly observed, an opium addict is accompanied by his son, whereas a brown sugar heroin addict is accompanied by his father (by which he was, of course, saying that opium addicts tend to be old people and brown sugar addicts young). Most of these addicts (93%) were either marriedand 6% were widowed or separated.

In terms of their religious affiliations, the respondents were mainly Hindus (98 per cent). This is partly because the Hindus are a majority in this region, where the Muslims constitute a significant minority (9 per cent). Though opium drinking has traditionally been associated with certain caste groups, our study has not controlled religion as a factor and so we cannot with any certainty make a statement on opium use among Muslims and Christians in this region.

Information collected about religious sects is not adequate, as about two thirds of the respondents ignored the question. Of those who gave their sects, a majority were worshippers of the Goddess (Mataji and Devi are terms used for the Goddess). Usually, Rajputs believe in the Goddess and the popular term for greeting each other is Jai Mataji (Hail the Goddess). The Rajputs worship the sun and consider themselves to be descendants of the sun (Surya Vanshi i.e. descendants of the Sun god). The Swaminarayans too constituted a sizeable number (14) of the respondents.

As mentioned earlier, opium consumption was traditionally and culturally associated with the Rajput/Kathi caste (including many different subgroups among them) which was a dominant caste in this region. Recently, however, the dominant status of the Rajput/Kathis has been challenged by the Patidars, who have established their dominant status in other parts of Gujarat (central and northern Gujarat). Castes other than the Rajput/Kathis have also started consuming opium. This is reflected in the caste distribution of the respondents. Although a little over fifty per cent of the respondents belonged to the dominant Rajput/Kathi caste (including 3 Charans), there was a sizeable number who belonged to other high castes-Brahmins (5), Banias (3), Patidars (16) and Khatris (2). Other middle and low level castes were also found in our sample. In all, about 16 different caste groups had the habit of consuming opium. This means that opium use is no more a behaviour of the dominant Rajput caste but is also found amongst almost all the sections of rural Saurashtra. Further focussed studies are required on this social spread.

Information about the native place of the respondents indicated that a majority of them had lived in the same place and had not migrated from any other place. All but two had their own house. The houses are classified into two broad categories, viz. poor and medium quality. The first category includes houses which are kachha (i.e. mud houses or huts). They constituted 54 per cent of the total. The medium category includes pucca(brick and cement) houses and those built in co-operative societies. A little less than half the houses (49 per cent) had two or less than two rooms. Facilities available in the houses of respondents were as follows: electricity-95 per cent, separate kitchen-91 per cent, bathroom- 46 per cent; tap/hand pump-29 per cent, and lavatory-22 per cent. There were only a few respondents whose houses had 5-8 rooms. Thus, opium use is no more a phenomenon of the rich and the powerful. It has percolated to all the classes.

Gender information regarding the respondents' family members shows that, on an average, there were 3.5 males to 3.1 females in each family. Family size was classified as being small, medium and large. We found that there were 16 per cent small sized families, 68 per cent medium sized and the rest were large families. The average number of members per family was 6.6 persons. On the basis of their nature, families are classified into two categories viz. joint and nuclear. A joint family is defined here as one in which the husband, wife and their married children, or any other relative stay. Such families constitute only 11 per cent of the total. The nuclear family is one in which only the husband, the wife and their unmarried children stay. About 89 per cent were nuclear families.

nus opium use is prevalent in small, edium as well as large families.

The literacy level of the respondents aried a great deal. About half of the spondents (51 per cent) were educated o to primary level, followed by 45 per- ent illiterates. A very small fraction (4 er cent) of the respondents were edu- ated up to the secondary level and be- ond. A large number of respondents' athers were illiterate (90 per cent). Only 0 per cent of the fathers had education p to primary level. About 86 per cent f the respondents were engaged in some ind of economic activity. About 11 per ent were retired and 3 per cent unem- loyed. Despite the fact that more than alf the respondents were above 50 years f age, it is noteworthy that 86 per cent vere engaged in some productive activ- ty. Here is a classic case of functional rug use, which is in total contrast to the tereotyped image of the drug addict that s projected by so many ill-informed pre- vention experts.

The occupational categories of the respondents reveal that two-thirds (66 per cent) were engaged in agriculture. A quarter were manual workers and only nine per cent were engaged in business or any other non-agricultural activities.

Nearly two thirds of the respondents (65 per cent) were farmers, 8 were work- ers, 11 land owners, 4 priests, 3 village guards, 1 driver, 1 teacher, 2 peons and 4 clerks. The annual income of the re- spondents was categorised into three broad groups. Below Rs. 5000 per an- num is the low income group in which there were only ten per cent of the re- spondents. The medium category cov- ers income between Rs. 5001 and Rs. 20,000; there were 76 respondents (48 per cent) in this category. The last cat- egory includes income above Rs. 20,000; 30 per cent of the respondents lay in this group. The average earnings of the re- spondents worked out at Rs. 18,363/an- num/person. Besides the respondents, other members of the family were also engaged in economic activities. On an average there was one male and 0.4 fe- male earners in the families. Including the respondent, the average number of wage earners per family was 2.9. If the earnings of the respondent were taken along with the earnings of other family members, the average total family in- come worked out Rs. 27,746/annum.

We found that opium drinking was prevalent among the landless as well as the landed. About a quarter of the re- spondents owned no farm land. A little over half of the land owning respondents (52 per cent) had up to 25 bighas (1acre = 2.5 bighas); 27 per cent of the opium drinkers in the study owned land mea- suring 26 to 50 bighas, and those own- ing more than 51 bighas constituted 20 per cent of the total landed respondents.

It has been observed earlier that opium addiction was prevalent among the dominant Rajput caste, the owners of villages presented to them by the kings or princes. The popular term for such Rajputs is Girasdar. The term Giras in local language means a morsel. Land was given to these Rajputs so that they might earn their livelihood from it. Such villages were called Girasdari villages. Only 26 per cent of the respondents be- longed to the Girasdar category while a large majority (74 per cent) did not have any Girasdari village land. Thus we see that opium drinking, which was a pre- dominant practice of Girasdars, has spread over time to non-Girasdars as well. Opium drinking, a practice of the political elite of yesteryears, has perco- lated to the masses in Saurashtra.

It has been observed earlier that opium addicts were generally considered respectable people. They were given positions of power and prestige. In that context, the question was raised as to whether the present day opium addicts held any position in their castes or vil- lage Panchayat. None of them held any position in a Taluka or District Council and 9% held position in Caste Panchayat and Gram Nagar Panchayat.

Age at the first use of opium

Opium consumption being tradition- ally an accepted practice in this area, it was found that a large number of addicts had started consuming opium after the age of 35. Twenty one per cent had started before the age of 25; a little over a quarter (27 per cent) had started be- tween the ages of 25 and 35; the rest (52 per cent) had started after the age of 35. The mean age at which opium consump- tion started was 34. While opium con- sumption is believed to be a problem of the old, the habit starts at a much younger age. Although opium consumption is a tradition, the respondents have given various reasons for taking opium. In the present study, four main reasons were given, viz. (1) friends were taking it (67 per cent), (2) due to sickness/disease (42 per cent), (3) to pass the time (35 per cent), and (4) to increase sexual potency (23 per cent). Thus the most common reasons for taking opium, given by two thirds of the respondents, was that their friends were taking it.

Place at which opium is consumed

Traditionally, opium was consumed either at the residence of the king, prince or landlord, (the residence was popularly called a 'dally' - a house surrounded by walls), or at the village Panchayat or in the company of relatives and friends at home. Consumption by individuals in the absence of company was not very popular. Nowadays, because of the NDPS Act, consumption of opium in public is not very prevalent. When the respondents were asked where they con- sumed opium, it was found that 69 per cent consumed it at home and alone. Only 37 per cent consumed it with friends.

Opium was traditionally consumed in the company of members of the same or similar status or caste. These days there have been some changes in traditional pattern of opium use. We found that about 32% took opium with their own caste members, 21 per cent take opium with members of their own and/or mem- bers of other castes and the rest 46% took with others. The total number of friends consuming opium was quite large in the past. Nowadays, the size of the group has changed with 31% of the sample usiig with two to three friends, but for a large percentage (53%) of the sample, the data is not available.

Frequency of opium consumption

Since opium consumption was pro- hibited by the NDPS Act, frequency of opium consumption ought to have de-

creased. However, from the data at our disposal, it was found that rather more than half (57 per cent) take opium at least once daily. Many of the users (35%) took opium once a day, 28% took more than once a day and 32% took one to four times a week. It is not easy to get the required quantity. Those who cannot get opium have switched over to opium pods. There are 32 such respondents. Among those who consume opium, 44% took 5 tola or less in a week, 27% took 10 tolas and less in a week. Two users took a maximum of 15 tolas (1 tola = 11.66 grams) per week. Those who consume opium pods consist of 10% of the sample and among them 2% use 200 grams of pod per week. Besides consumption at the personal level, the practice of consuming opium at various other occasions, like marriages and deaths, is also prevalent. These days, opium is also consumed during election meetings, festivals and during events when some conciliation takes place.

Manner of opium consumption

As mentioned earlier, the usual practice of taking opium was a group setting and in liquid form, commonly known as Kasumba Pani. Another way of taking opium was in the form of small granules. This was called Rogu. The former method (Kasumba Pani) was prevalent among the dominant Rajput caste, during the dayro. The present respondents still favoured opium consumption in liquid form (59 per cent). About one third consumed it in the form of granules. Due to the non-availability of opium, a large number of respondents (90 per cent) also took opium pods soaked in water. In this case, opium pods are soaked in water for a long time (about 12 hours) and then this water, which contains essence of opium pods, is consumed. About ninety per cent of the respondents said that they could not get pure opium.

Other addictions/habits

Accompanying their use of opium, the addicts developed various other habits, like taking tea, enjoying a hooka or chillum, or taking snacks. A large number of respondents (96 per cent) said that they took tea and eighty-seven per cent said that they either enjoyed a chillum, hooka, beedi(all indigenous varieties of smoking) or tobacco. Since opium consumption requires the addicts to consume other rich food, we asked the respondents whether they make use of such nutritional food. Only seventeen respondents said that they consume milk, ghee or other rich food along with opium.

Permit for opium pods

In the absence of pure opium many respondents have switched over to opium pods. It was found that permits for opium pods are given on medical grounds. It was also found that during election time candidates helped opium addicts to acquire permits for opium pods. About forty eight per cent of the respondents said that they had permits for opium pods. However, many complained that they did not get enough pods even though they possessed permits. These respondents said that there are very few shopkeepers who have a license to sell opium pods. Even those who possess a license do not get a large enough quantity of opium pods. When the permit holder goes to buy from a shopkeeper, the latter does not supply the prescribed quantity but sells the balance on the black market. Only one quarter of the respondents said that they received their full measure of opium pods. Fifty six per cent got what they required from the black market. Thus, with the promulgation of NDPS Act, the practice of opium consumption has now resulted in black marketering. Besides opium addiction, respondents had other habits too. The other habits were Beedi/Cigarette (84 per cent), Tobacco (35 per cent), Pan/Masala (35 per cent), Hooka (34 per cent), Chillum (27 per cent), Liquor (15 per cent), Ganja (12 per cent), Bhang (6 per cent), Snuff (5 per cent) and Charas (5 per cent).

Special food consumed with opium

It has been observed above that those who consume opium have to consume rich and nutritious food to get rid of its negative effects.

The respondents were asked about the type of food they consumed. A large majority (87 per cent) were found to be vegetarian, whereas only 13 per cent were non-vegetarian. The low percentage of the non-vegetarians amongst them can be explained thus: due to the increasing trend of sanskritisation (i.e. emulating the values of the dominant class) many of the castes eating non-vegetarian food tried to give it up.

Since this type of rich food is costly, opium consumption is called a rich man's habit. The respondents were asked whether they took any special food along with opium. Only 26 of them said that they did take food like milk, ghee, eggs and almonds. Those who did not take special food were asked whether they needed to take it. About one third said that they did need special food.

Amount spent on opium

The respondents were asked about the amount that they spent on opium consumption per month. Since opium is already costly and is not available in the open market, the addicts have to buy it from the black market, which means that they have to pay much more than the actual cost of the opium. But since many have switched over to opium pods, which are less expensive, the cost is not as high as it otherwise would be. Forty-six per cent of the respondents spent less than Rs. 100 per month. The remainder spent between Rs. 100 and Rs. 500. The monthly average works out at Rs. 131. Even though the amount is not very high, in the context of a village economy, it is quite costly. A large number of the respondents are old and they are dependent on their relatives for their extra expenditure on opium consumption. Secondly, villagers do not earn a monthly income. Their income is usually at the end of the harvest season. Therefore, to get cash every day or each week to purchase opium or opium pods is quite a difficult thing.

Whether the respondents can afford opium addiction

Opium consumption is an expensive habit and once a person becomes addicted to it, he has to spend the same amount or more each day to satisfy the habit. Many addicts ruin themselves to feed their habit. Therefore the respondents were asked whether they could afford to finance it. A little more than half

3 per cent) of the respondents said that ey could bear the cost of this habit. nose who could not were asked what ey do to get the extra money. It was ound that 36 per cent had borrowed oney, 11 per cent had mortgaged their nd and 31 per cent had sold their land or naments. This negative impact of opium onsumption needs further analysis.

nfluence of excessive onsumption

Only a limited amount of opium onsumption can be tolerated by the onsumer. If by mistake the consumer akes more than the required quantity, e may suffer from various side ef- ects, sometimes culminating in death. For this reason, very often people who vant to commit suicide consume an xtra dose of opium. In Saurashtra and Gujarat women sometimes end their ives by these means. Sometimes the abitual addict also takes more than he required quantity of opium. The espondents of the study were asked whether they had at any time consumed excessive quantities of opium. About one third replied in the affirmative. They were further asked what they did n such cases. A large percentage of hem (65%) said they did nothing about it. Other said they took lemon uice (16 per cent), butter milk (13 per cent), applied cold water to the head and rested (4 per cent), and slept with- out taking food (1 per cent).

Effects of opium consumption

Opium has many negative consequences. It can affect the health of the person in many ways. Besides this, he may develop many other side effects if he does not get opium in time. Our respondents were asked whether they had experienced any effect on their health. It was found that a large majority (75%) did not experience any side effect and from the remaining 3% experience positive side effects and 18% experienced negative impact. Those who said that opium consumption had negative consequences on their health, mentioned that they developed swelling of the liver, breathlessness and weakened eyesight.

Opium consumption may also affect the occupational life of a person. About three-quarters of the respondents did not find that opium consumption had any effect on their occupation. Five respondents found that they could do much better work with the help of opium. Twenty respondents said that they felt bored and thirteen others found themselves disorganised in their work.

Over and above the impact on occupation, opium addiction has a generalised impact on the economic condition of the addict. This may include his household possessions, his ability to spend money on his daily needs, his ability to spend on his children's education, and getting his children married and settled in life. In this connection, respondents were asked whether opium consumption had in any way affected their economic condition. It was surprising to find that a large majority of the respondents (83 per cent) reported no effect. Only 17 per cent reported a negative effect, whereas one respondent found that his economic condition had improved.

Opium consumption also has an effect on family prestige. In the past opium addicts were considered respectable people and there was no loss of prestige on their part. But, in the changed circumstances, the weakening economic condition of opium addicts has brought down their family prestige. However, in the case of the present respondents, a large number of them (94 per cent) said that their family prestige had not suffered due to opium consumption. It also affects the addict's relation with his family members. In this case, it was found that about 62 per cent respondents said that their family had no objection and 34% did not like it but tolerated it. Only six respondents said that their family members objected to or opposed it. The family members' reaction has to be seen in the context of the essentially patriarchal family culture, in which the male members of the family dominate in decision making and the female members and the children usually are subject to those decisions.

Attempt to get rid of the addiction

Since addiction is supposed to have adverse effects on the health, occupation, economic condition, and family prestige and the addict's relations with family members, it is but natural to enquire whether the addicts themselves wished to get rid of this habit. The scarcity of opium is also one reason why the addict might think of getting rid of the habit. In the present study, when the respondents were asked whether they experienced any difficulty in getting opium, 48 per cent said that they did not, whereas the rest of them said that they did experience difficulty and that they had to get it from the black market.

Because of the respectability and legitimacy traditionally accorded to opium consumption, the Bandhanis, who can consume opium in large quantities were also respected. The respondents were therefore asked whether they considered themselves Bandhanis. About two thirds said that they did.

A large number of respondents (82%) reported that other members in their family were also addicted to opium. Thus, besides the respondents, the family also had other members taking opium.

The respondents' willingness to relinquish the habit will be affected by their perception of the harmful effects of opium. When asked the global question as to whether they considered opium consumption harmful, a little more than half (54 per cent) said that they did, whereas the rest did not find it so. When asked in what different ways opium consumption was harmful, 18 per cent thought it harmed occupational and economic activities, 39 per cent thought it was physically and mentally harmful, whereas the rest considered it harmful for unspecified reasons.

Earlier we found that, in response to a question regarding the effects if opium consumption on health, occupation, economic condition, familial relations and family prestige, a high percentage of responses conveyed no negative consequences. However, when answering a global question about harm, those indicating that the effects were harmful con-

stituted a sizeable proportion. The discrepancy in responses may be partly because of the way in which both questions were framed-the previous one being specific but the latter general. The discrepancy is partly because of the confusion in the perception of the respondents. As part of their traditional culture they find nothing wrong in consuming opium, whereas in the context of the NDPS Act they tend to perceive it as harmful. When asked whether the respondents had attempted to get rid of their opium addiction, 87% never attempted to give up drugs. Among those who tried to give up use (23%), most of them were not successful because of various after-effects of their attempts. Respondents were further asked whether they still desired to get rid of this habit, but only 32 of them expressed such a wish, only seven being willing to be treated at the de-addiction centres.

Respondents' perceptions of the ban on opium consumption

All the respondents were familiar with the NDPS Act banning opium consumption because they found it difficult to procure opium as easily as they did in the past. They were asked whether they perceived any change in the practice of opium consumption after the ban. Only 40 per cent said that there was some change. When asked whether the practice of opium consumption had increased or decreased, the respondents were divided between those who said that it had decreased (44 per cent), those who said that it had increased (14 per cent) and those who said that there had been no change (42 per cent).

Chapter 4

CONCLUSIONS

To conclude, we find that the 158 opium addicts from 12 different villages of the six districts of Saurashtra are predominantly married Hindu males with an average age of 56, belonging mainly to the dominant Rajput caste, with a fair representation from other upper and middle castes, living in joint families, and engaged mostly in agricultural activities. Their annual family income is Rs. 27,745, which works out to be slightly more than Rs. 2000 per month.

Unlike in the past, most of them do not hold any position of power or prestige in their village community.

The average age at which they started taking opium is 34 and about two thirds of them started the habit because of their friends. Most of them do not get pure opium and therefore many have started taking opium pods, which they get from the black market. About half of them consider opium consumption harmful but very few (23) of them have attempted to get rid of the habit, and fewer still were willing to be treated at the de-addiction centres.

An important aspect that requires further study is on the 'opium drinking career' or the natural history of opium drinking. We need to find out how many occasional or recreational users move on to become regular users; how many become problem users; how many become dysfunctional; how long it takes for a person to progress from the first use to dysfunctional use. Is it ten, twenty, thirty or forty years? What factors facilitate such a negative course? What protects a person from sliding into a dysfunctional use of opium?

While in the case of heroin ('brown sugar') the average age at first use is below 20 (NARC Patient Data Analysis Report, November 1994), we see here that the mean age at first use of opium was 34. By that age the respondents were married adults.

After having studied the profiles of 158 opium drinking respondents, let us deal with the background information of addicts treated at a de-addiction centre at Veernagar, in Rajkot district.

Secondary data on patient profile was also collected from treatnent centre in Rajkot. The centre had information on 1218 cases recorded at their hospital from the year 1989-90 to 1993-94. The patients were being treated for different types of drugs, like opium, brown sugar, alcohol, unspecified injectables, charas, ganja and tobacco. From the total number of patients, 607 were opium users and 470 were alcohol users. It is interesting to note that between 1989-190, 114 persons were admitted for opium use and 55 persons for alcohol. The total number of persons admitted during that period for all types of drug use was 183. Two years later, the total number of persons was 332, from which 144 were opium users and 139 used alcohol.

Out of 607 opium addicts who were registered at the de-addiction centre, we have background information on 468. The following description is based on the background data of these 468 opium addicts. Except for one solitary female, all the opium addicts are male. Half (51 per cent) belong to middle age, i.e. between 36 and 56 years. The young addicts constitute a little more than a quarter (27 per cent) and the old addicts account for just under a quarter of the total. These patients come from various parts of Saurashtra. To be precise, they come from 207 villages in 61 talukas of six districts of Saurashtra. In other words, they come from almost all the parts of Saurashtra. A large majority of the patients (56 per cent) are illiterate. Among those who are educated, about a third have studied up to primary level. Since Hindus constitute a predominant majority in this region, the patients are mainly Hindus (96 per cent). There are only 16 Muslims and one Christian among them. The patients belong to three caste groups, viz. the upper castes, which include castes like Brahmins, Bania, Patidar etc. constitute only 12 per cent. The dominant caste, which covers castes like Rajput, Darbar and Kathis, form about 22 per cent. The third category is an open one and includes all other castes. They constitute about two thirds of the opium addicts.

Obviously this background information is very limited but it is presented here to get a profile of opium addicts who visit the de-addiction centre. Though information about the occupations as recorded in the register was not very precise, it was found that about a third of them are engaged in agriculture and about one half are manual workers. Information about their monthly income was also not adequately recorded but it is found that most of them had an annual income of less than Rs. 10,000. Since a large majority of patients are of an advanced age, most of those for whom statistics are available are married. Information about the duration of the use indicates that at least 45 per cent have been using the drug for over ten years, over a third of whom have been using it for over twenty years.

In short, opium addicts, who have received treatment at the de-addiction centre, are predominantly Gujarati Hindu males, with an agricultural background and low level of education. A majority of the drug users came to the hospital within ten years of drug use. The information provided here supports the primary data received from the 12 villages of this region.

Chapter 5

CULTURAL STRATEGIES OF INTERVENTION

In the foregoing chapters we have provided a brief description of Saurashtra region, its culture and the place of opium in it. We have also described how opium consumption is practised in its rural areas.

In the present chapter we shall dwell upon the various cultural strategies, whereby the negative consequences of opium consumption can be eased, if not completely eliminated. The interview data obtained from 158 respondents indicate that opium consumption is no longer confined to the dominant Rajput-Kathi castes. Because of the change in power structure and economic progress, the stagnant society of the past has become relatively open and dynamic. As a result of this, many castes, which were not so powerful and prosperous, have come up and scaled the prestige ladder in their attempt to imitate the earlier feudal castes; they have also started taking opium. In other words, the problem of opium consumption has become a mass phenomenon instead of a class phenomenon.

Secondly, the interview data also show that the opium users do not get pure opium. Many of them continue to consume impure opium. Some have switched over to opium pods. The Act banning the sale and consumption of narcotic drugs has made it difficult for the opium users to get their quota of opium/ opium pods. Moreover, they have to pay more for their habit because they have to get the stuff from the black market. In spite of these difficulties the interview data show that many of the opium users are not properly aware of the negative consequences of their habit. It may be possible that they do not want to accept its obvious negative effects. Hence, only a few addicts resort to treatment at the de-addiction centres.

Even though opium addiction is a part of the past tradition of this region, the interview data show that a majority of the opium addicts have started the habit because of their friends. The present day political situation has also been supporting this particular practice. While collecting the data, the investigators were told that during election time licenses for opium pods were freely available and opium consumption was practised on a large scale. The candidates contesting elections were required to have a large quantity of opium in order to ensure their success.

The act banning opium consumption has deprived it of its legitimacy and respectability. On the contrary, opium consumption has now become an activity, which is not legally allowed, and those who indulge in it invite punishment as per the Act. This has made opium addiction a part of an underground activity. Like Prohibition in the USA, which increased criminal activity, opium consumption, or for that matter any drug use, is considered to be a criminal activity. The only redeeming feature of this disappointing scenario is that the problem involves a large segment of old people and to that extent one may presume that it is a problem which will, in course of time, disappear. But the impact of wider forces, like economic prosperity and democratic elections, have given support to the practice and more and more young people are likely to become addicted to this drug.

In a situation like this, what are the various cultural strategies for intervention? One obvious reason why people, irrespective of their class, caste or community, become addicted to opium is that they have considerable leisure time at their disposal. This is partly due to the nature of their work, i.e. agriculture, which is largely dependent on rainfall. With rainfall absent (which is quite common in this region) and with the relative lack of irrigational facilities, the farmers have no income producing work to do for a major part of the year. Improved and expanded irrigation of their land would provide them with enough opportunities to remain engaged in their work. However, it is not easy in a drought prone area like this to have greater irrigational facilities. Another way in which these people can be kept more engaged is to develop various other agro-based industries like horticulture, pisciculture, sericulture etc. Yet here again the restrictions of castes against their members taking up certain so-called 'unclean' occupations will provide a dampening effect, because some of the occupations, like raising silk worms, bees and fowls, are considered unclean by the twice-born castes.

Another way of keeping the idle population occupied is to engage them in various community activities like spreading literacy, popularising family planning etc. However, the snag here is that most of the addicts are themselves illiterate and devoid of general social awareness and therefore they can not be drafted into these types of activities. However, there are activities like popularising small saving schemes etc. in which they can be involved.

One reason why opium addiction has attained a measure of respectability and legitimacy is that the Bard-caste, i.e. Charans/Gadhavis, have praised it in their literature. Nowadays we do not find the Bard-caste glorifying the practice of opium consumption. This is because there are no princely courts to give them encouragement. The same caste can now be employed to highlight the negative consequences of opium addiction. Dayro as an institution has assumed a distinctly different form nowadays. The traditional folk artists (Gadhvis included) entertain people by singing duhas and telling folk tales. Such dayros can be used to publicise the evil effects of opium.

Culturally, opium consumption does not fit well with similar practices, like smoking cigarettes, drinking alcohol, or chewing tobacco/pan masala. Most of these habits are associated with a westernised behaviour model. Moreover it is also easy to smoke a cigarette or enjoy a glass of wine, whereas preparing opium liquid is a laborious process and those who partake in it become physically dirty. In this sense opium consumption is not likely to become popular among educated youths. This par-

ticular negative aspect of opium addiction can be highlighted in order to restrict its spread. But whether opium addiction will get substituted by more pernicious ones such as alcohol and brown sugar is a moot point.

Some of the religious sects and religious saints belonging to the Bhakti (devotion) cult have preached against various types of addictions in general and opium addiction in particular. Their views, expressed in various poems, sayings and parables, could be explored and made public. The village people tend to be guided more by the preaching of such traditional saints and religious leaders, whose views can be an effective medium through which the problem of opium addiction can be tackled.

Opium addicts also need treatment at the de-addiction centres. There are few such centres. In the whole of Saurashtra there is only one centre, located near Rajkot at Veernagar. (The information regarding patients who visited this opium centre as addicts is analysed in this report). Those who need treatment are often unwilling to seek it. More de-addiction centres need to be started and efforts should be made to overcome the addicts' reluctance to use them. The doctors, nurses and social workers who work in this area should also be acquainted with the cultural context of various drugs so that they can effectively provide guidance and treatment for the addicts.

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Monograph 3:

CULTURE AND DRUG ABUSE IN KARNATAKA

Prof. S.V. Joga Rao

AUTHOR'S PREFACE

I express my sincere thanks to Dr. N.R. Madhava Manon, Director, National Law School of India University, Bangalore, for giving me permission and encouragement to conduct this socially relevant and intellectually stimulating exercise.

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S.V.JOGA RAO

Chapter 1

INTRODUCTION

Perceptions:

"Ganja smoking is necessary to increase one's appetite".

"When the bride and bridegroom assemble for the ceremony of marriage, the bride's family is expected to distribute ganja to all the invitees; it is a well known customary practice".

"In the festival of Saint Shishunal, every devotee considers ganja smoking as a religious obligation".

"Chewing ganja helps us to get over anxiety and weariness during work hours".

"Ganja smoking is a part of our day to day life".

(Source: respondents of the present study)

The problem:

Drug consumption is as old as human civilisation. History records the debate revolving around socio-economic and political issues relating to drug cultivation and consumption, coupled with a strong sense of social acceptance. This fact is universal, well documented and indisputable. However, over the years, many parts of the world have responded to these practices by criminalising the use of non-medication drugs, particularly on the grounds that their consumption would lead to addictive habits, resulting in health hazards. The criminalisation approach has received further support in view of the proliferation of numerous addictive substances with advances in science and technology. Some of these have been derived from traditional agro-based drugs. At the same time, it should be noted that these were developed by pharmaceutical research to meet medical needs.

The expression 'misuse' or 'abuse' connotes consumption of drugs for a purpose other than medical. Three broad categories of drugs 'abused' are (a) substance which are purely agro-based, like ganja, opium, coca, (b) drugs which are derived or synthesised, like brown sugar, heroin and cocaine, and (c) pharmaceutical drugs, like morphine, pethidine etc., having narcotic effects but purely meant for medical purposes. A scholastic review of the laws of different countries in the world indicates that cultivation and consumption of the above-mentioned categories of drugs have been criminalised in a large number of them, although in recent years a slow review and reversal is visible.

India is no exception to this kind of approach. The prevailing legal framework has wholly criminalised the acts of cultivation and consumption of drugs. Yet, the process has failed on all its fronts to control drug abuse; instead, the problem has become exacerbated and threatening, in view of the deadly consequences of the spread of Human Immunodeficiency Virus (HIV) among injecting drug users (IDUs). It is felt that there is a dire need for viewing the drug problem from the cultural and user perspectives, at least in the area of consumption of those drugs which have had deep-rooted social involvement and acceptance. Hence this research.

Chapter 2

HISTORICAL PERSPECTIVE

In this chapter we describe the social, religious and cultural dimensions of drug consumption in history and, in the next chapter, critically examine the existing legislation governing drug use.

History of mind altering substances

Cannabis drugs (bhang, ganja and charas) have been commonly used for mind altering in India from time immemorial. The plant grows wild throughout the foothills of the Himalayas, the neighbouring states, and almost in all parts of the country. The poppy plant (papaver somniferum) can grow in several parts of the country and is always cultivated. Its product, opium, has been used in India since the seventh century. Its derivative, heroin, has not been abused on any significant scale until the 1980s. Therefore, the drug scene in India mainly relates to the use or abuse of opium and cannabis.

Use of cannabis in medicine

Cannabis was an important drug in the traditional systems of medicine (TMSs), such as Ayurveda, Siddha and Unani, both in folk/tribal medicine systems as well as in home remedies. It has been used for the treatment of both human beings and animals. It is still used in these TSMs. In rural areas, it is popularly considered to be a remedy for diseases like dyspepsia, pain, rheumatism, diarrhoea, hysteria, gonorrhoea, cholera, etc. For medicinal purposes, the drug is administered by mouth and is not smoked. Use of cannabis to relieve fatigue, strain and worry is also common. It has been observed that in Punjab and some other states, the use of ganja and bhang increases during the harvest season by fifty per cent. The number of individuals who use bhang as a medicine is greater than those who use ganja. Bhang has a milder action and is used as an anti-spasmodic more frequently than ganja or charas (Chopra and Chopra, 1990).

Socio-religious dimensions of cannabis

Ascetics and saints often consume cannabis drugs to overcome hunger and thirst. Under its influence they can go without food for a number of days. There is also a belief among them that these drugs help them to concentrate on meditation. Bhang is associated with many rituals performed in some of the Hindu temples. Shivaratri and Holi festivals are occasions for consuming bhang. Among certain sects in Bengal a beverage prepared from hemp leaves is offered to family members and guests present on the last day of Durga Pooja. Ganja is used as an offering in Tarkeshwar temple on Shivaratri day and on festivals such as Trinath Pooja. In Jagannathpuri (Orissa), ganja and bhang are used by the attendants and worshipers of the Lord Jagannath (Raina, 1990).

History of opium

The poppy has come to be widely grown in many regions of the country. Cambay and Malwa are the first recorded areas of poppy cultivation in the 15th century. In the Moghul period its cultivation became extensive and opium was an important article of trade with China and other eastern countries. In the battle of Plassey in 1757 the British defeated Siraj-ud-Daulah Mir Jafar, Nawab of Bengal. After this battle, the British acquired an opium monopoly. Behar (Bihar) was the province where the best quality of opium was produced in large quantities (Shah & Hussain, 1983).

Use of opium in medicine

It is generally accepted that opium was introduced into India by the Arabs, who conquered Spain, Egypt, Asia Minor, Turkistan, Persia and other parts of India in the seventh century AD However, some consider that it was introduced into India by Alexander the Great in 30 BC.

According to Ritter (Veselovskaya, 1976), the poppy was brought to India for cultivation by the Mongols in the middle of the 13th century and later it became widespread in the Malwa region of Madhya Pradesh. However, Veselowskaya suggested that the cultivation and uses of opium in India were introduced as early as the 7th century by the Arabs, whose influence was much stronger than that of the Mongol's.

Over the years, the poppy came to be widely cultivated in many regions of the country. Cultivation appears to have begun in the coastal areas and later spread to the interior.

No reference has been made in the ancient books on Ayurveda medicine either to the poppy or its products. It is difficult to ascertain when exactly opium was introduced into Ayurvedic medicine. There is no mention of opium in the classical works of Charaka Sushruta and Vaghbatta. The latter work is believed to have been written in the sixth century. A work on toxicology by Narayan and Malabar (about AD 862) mentions the use of opium in the treatment of rat poisoning. The author and commentator, Chakrapani Dutt, who, according to his own writings, lived in the reign of King Nayapala of Bengal (eleventh century), does not mention opium in his work on medicine, 'Chakradutta'. In the later works, opium is frequently mentioned and was used in several preparations. There is no clear-cut evidence as to when opium was first used in India for medical purposes. According to Sharma (1973), the earliest description of the poppy in Indian literature is available in Dhanwantri Nighantu (c. 1000 AD). Its medicinal preparations are described in Shodal Gadanigraha, c. 1200 AD, and in Sharanghar Samhita, 1400 AD, where its use is prescribed in diarrhoea and sexual debility.

Administration of opium was apparently limited in the Ayurvedic medicine to control diarrhoea, to increase sexual and muscular prowess, and to relieve pain and spasms. Its sedative properties have not been much used by Ayurvedic physicians.

The Unani/Tibbi physicians had extensive knowledge of this drug and used it widely. They had derived this knowledge from Arabian medicine, where opium is described as an anaesthetic and analgesic. Opium is prescribed by the Tibbi physicians for relief of pain in the head, eyes, ears, teeth and joints; drying of catarrh, allaying of coughs, asthma and hiccups; treatment of manic delirium and the inflammatory conditions of the brain; treating diarrhoea and dysentery; treatment of paralysis agitans, facial paralysis, epilepsy and similar nervous conditions, and curing intermittent fevers (Chopra and Chopra, 1990).

Itinerant medical practitioners, village wise men and shopkeepers administer opium for a large variety of common ailments, such as cough, bronchitis, asthma, diarrhoea, dysentery, colic, chills, piles, recurrent febrile attacks, malarial fevers and cachexia, rheumatic pains, diabetes, grave nervous troubles and indeed all painful and wasting diseases of every kind.

Socio-religious dimensions of opium

The customs in some parts of the country required that opium should be distributed among the smokers present on occasions such as marriages and funerals. Not long ago a ceremony purporting to be of a semi-religious nature, the Kenia Seba, was found to exist among the poor in Assam at which opium addicts assembled and opium was distributed with the object of averting sickness or other troubles sent by Providence. The distribution and consumption of opium was also common at Namagoe (the name-giving ceremony). These semi-religious uses of the drug had no authority from the Shastras (religious books). Though they are not part of the Brahminic/Aryan religious tradition, were they part of the subaltern streams of religion in the country? Did the numerous little traditions support this practice? Did drug use have a role in the Dravidian religious mores? Further study is required to address these larger questions in a multi-disciplinary manner. In some parts of the country, the use of drugs was frowned upon by the higher classes, whereas in other parts of the country it was the dominant castes who indulged in opium consumption and provided legitimacy to it. In some places, it has now practically disappeared. Madak smoking as a social function in Assam formerly existed on an extensive scale, when opium was not only easily available but also cheaper in price. Similar practices of opium smoking have been observed in other parts of India also. The two previous monographs in this book contain studies of opium consumption in the desert regions of India. The present research restricts itself mainly to the use of cannabis in two districts.

Chapter 3

THE POLICIY AND THE LAW

Cannabis policy of the British era

During the Mughal period, cannabis was grown and its preparations were manufactured throughout the country without restrictions. In a sense, it was encouraged for domestic and medicinal purposes. Only since the middle of the 19th century has cannabis begun to be perceived as having injurious social effects. The British Government of India took note of the effects produced by the habitual use on cannabis drugs in large quantities. In 1893, a Royal Hemp Commission was appointed to go into the whole question of the use of cannabis by the people. On the recommendations of this Commission, Act XII of 1896 was passed empowering the government to exercise absolute control over the cultivation of cannabis plant and the preparation, import, export and transport of drugs therefrom.

With reference to ganja and charas, the following policy guidelines were laid down:

That the cultivation of cannabis plants in British India for the preparation of these drugs should be restricted as soon as possible, the production of ganja and the import of charas being, however, permitted under proper control and restrictions;

That production of ganja and charas or import into any state be liable to a direct quantitative duty, such duty being paid on issue for consumption from the bonded warehouses where the drugs were to be stored but to remain the property of the cultivators, dealers or importers; and

That the drugs should be allowed to be freely carried under suitable restrictions but without payment of duty from one warehouse to another within the same or into another province, the duty being realised therefrom on issue from the warehouses for retail sale in the provinces of consumption.

Opium policy of the British era

In 1773, the Governor of Bengal assumed monopoly of all the opium produced in Bengal, Bihar and Orissa on behalf of the East India Company. Warren Hastings as Governor-General brought the whole of the opium trade under the control of the government. Since then, though changes have been made in the policies of control, production, distribution, sale and possession of opium, the monopoly has been solely in the hands of the government and strict control has been exercised.

The British prohibited cultivation of poppy and production of opium except in a restricted area under licence. Permits were issued for:

Patna or Bengal opium, from poppy grown in Bihar and Bengal;

Benaras opium from the United Provinces;

Malwa opium produced in a large number of the princely states of Rajasthan, Gwalior, Bhopal, Baroda, etc.

In 1813, for the first time, the government enunciated a policy for restricting the opium eating habit by obtaining maximum revenue from the minimum consumption and declared that they were desirous of countenancing, only to the narrowest extent possible, a habit which they found themselves unable to eradicate. Then in 1893, as a result of the activities of the British Society for the Suppression of the Opium Trade, a Royal Commission was appointed to inquire into the circumstances connected with the production and sale of Indian opium. The report of the Commission vividly illustrated the historical pattern of opium use in India, and its recommendations formed the basis of British opium policy practically until 1947. The Commission concluded that opium in India was for oral consumption by adults and children; that this use was by a 'small' percentage of the total population and was generally moderate with no evidence of harmful physical or moral effects; that the use was due to the universal tendency of mankind to take some form of substance to comfort or distract themselves and due to a popular belief in the medical purposes, because of the ceremonial and social uses to which it was put and its acceptance by Hindus, Muslims and others. The Commission also feared an increase in alcohol consumption if opium was prohibited. The opium policy of the British Government of India is contained in the famous despatch of Lord Hardings in 1911 which had become, as it were, a locus classicus of the then Government of India on the subject. It reads as follows:

"The prohibition of opium eating in India, we regard as impossible and any attempt at it is fraught with the most serious consequences to the people and the Government. We take our stand unhesitatingly on the conclusions of the Royal Commission which reported in 1895, viz., that the opium habit as a vice scarcely exists in India; that opium is for medical purposes, in some cases with benefits, and for the most part without injurious consequences, that the non-medical uses are so interwoven with the medical uses that it would not be practical to draw a distinction between them in the distribution and sale of the drug, and that it is not necessary that the growth of the poppy and the manufacture and sale of opium in British India should be prohibited except for medical purposes."

"Whatever may be in other countries, centuries of inherited experience have taught the people of India discretion in the use of the drug and its misuse is negligible feature in Indian life. Even if it were possible to suppress the cultivation of opium in India, geographical and political considerations would place it beyond our power to prevent illicit import and consumption on a serious scale." (Mohan et al., 1981).

Legislation

Principally, there were three enactments dealing with drugs until the year 1985: (1) The Opium Act, 1857, (2) The Opium Act, 1878 and (3) The Dangerous Drugs Act, 1930. These are briefly described here.

The Opium Act, 1857

The statement of objects and reasons of The Opium Act, 1857, were:

"The existing law relating to the cultivation of poppy and the manufacture of opium on account of Government is in some respects inconsistent with the practice which now obtains under agreement between the opium agents and the cultivators, and it is expedient that such inconsistency should be removed. It is also expedient to consolidate and amend the law relating to the cultivation of poppy and the manufacture of opium."

The thrust of the Opium Act, 1857, was mainly towards the regulation of licensing procedures and to avoid embarrassment as far as opium cultivation was concerned. The object of the act was not to criminalise the process of import, export, sale or possession, but to regulate and properly co-ordinate the cultivation of the opium poppy. Therefore, the act mainly concentrated on procedures relating to the issuance of licences to the cultivators of the opium poppy and the supervision of cultivation. The act also provided for confiscation of produce if a cultivator failed to supply to the government depot the expected quantity of opium harvested. Punishments up to one year's imprisonment were provided in cases where the produce was confiscated.

The Opium Act, 1878

This is the first act to consider the possible abuse of opium and therefore is a landmark in the chain of drug laws. The act vested certain powers in the state governments to regulate possession, transport, inter-state import and export, and sale of opium.

The opium Act, 1878 was an indication of the government's reaction to the so-called drug problem. As such, there were no documented findings to indicate any evil effects; rather, there was material which illustrated the cultural dimension.

However the act became obsolete in six decades due to the proliferation of different dangerous drugs. In addition, new developments at the international level, namely the holding of the Geneva Dangerous Drugs Convention, 1925 and its ratification, necessitated the enactment of the Dangerous Drugs Act, 1930. The scope of this act included not only opium but also a variety of other drugs.

The Dangerous Drugs Act, 1930

Within a span of about half a century after the enactment of the Opium Act of 1878, drug abuse seems to have established itself and become an international issue. The objects of the Dangerous Drugs act, 1930 give a clear picture of the intensity of the problem felt at that time. It mentioned that in view of the obligations undertaken by the Government of India by ratifying the Geneva Dangerous Drugs Convention, 1925 and the existing confusion of the laws governing the traffic in dangerous drugs in British India, it has become necessary to enact a Central Dangerous Drugs Act. The obligations that have been so undertaken by the Central Government are two-fold: firstly, in regard to the regulation of international traffic in all the drugs covered by the convention, and secondly in regard to the regulation of the manufacture of, and internal traffic in certain specified drugs, such as cocaine and morphine.

The Dangerous Drugs Act, 1930 was the first enactment which took note of both natural and synthetic drugs and thus had enhanced scope.

With the national movement for Independence, prohibition of all intoxicants including opium became one of the major policy issues with the Indian leadership. Among many petitions presented to the International Opium Conference of 1925 in favour of the worldwide restriction of the traffic in narcotic drugs to the needs of medicine and science was one from India. However, the British did not respond positively to this growing sentiment among Indian leaders against opium use.

The use of opium in India evoked much criticism at this time in international circles, especially from America, and the policy of the Government of India was attacked not only on moral and health grounds but also on the score of alleged illicit traffic from India. In 1944, the U.S. government started exerting pressure on the British government to give up the prevalent opium policy. Considering the general feelings in both domestic and international quarters, the British started taking steps towards reducing the production and consumption of opium in the country.

Post-Independence period

With Independence, under the new Constitution of India, a ten year programme was launched to eliminate in its totality the non-medical and quasi-medical use of opium in all forms by 1959. This did not occur.

The aim of the Government of India had been that cannabis must go the way of opium, i.e., prohibition at some future date. Prohibition of ganja and bhang appeared on the agenda of the All India Narcotics Conference, 1956. The official record of the stand taken by the Central Government was that, though these drugs were not quite so deleterious in their effects as opium, they must sooner or later be prohibited; and it had to be sooner rather than later, not only because international opinion was against the use of hemp drugs but also because of the hostile feeling in our own country. It was resolved by the Conference that the non-medical use of ganja and bhang should be totally prohibited throughout the country by 31st March 1959 and 31st March 1961, respectively. However, it proved impractical. Hence, it was resolved that the area under cultivation should be restricted to the minimum requirements of ganja and the limits of individual possession should be fixed at a very low level (23gms).

In 1964, India ratified the Single Convention of Narcotic Drugs of 1961, thus committing herself internationally to a total prohibition of the non-medical use of cannabis drugs. However, for practical reasons, a reservation was entered under Article 49 of the Convention in accordance with which the licit consumption of cannabis (ganja and charas) was required to be terminated by the year

989. However, bhang made of cannabis aves without the addition of flowering ps and seeds is not within the purview the Single Convention of the United ations (1994). It is also not prohibited nder the Narcotic Drugs and Psychotro- c Substances act of the Government of ndia enacted in 1985 (B.V. Kumar, 1990).

Emergence of Narcotic Drugs and Psychotropic Substances Act, 1985

Between 1930 and 1985, major hanges had taken place in the interna- onal scene regarding the means to be dopted for controlling drug abuse and rug trafficking. Several conventions, trea- es and declarations have been passed to onfront this problem on a unified front. The Golden Triangle and the Golden Cres- ent are the two major sources of opiates n the world, and they are placed on the ortheastern and northwestern borders of ndia, while Nepal in the north is the ma- or source of cannabis. Being placed at the centre of the three major points, India has become vulnerable to the transit of drugs. Trafficking apparently has reached its peak n recent times. Around the year 1980, Pakistan banned the cultivation of opium. However, it continued in some parts. About 200 metric tonnes of opium are il- legally produced every year. Afghanistan and Iran produce about 400 metric tonnes each. Thus the Golden Crescent produces about 1000 metric tonnes, a major portion of it being converted into heroin in the lo- cal refineries. Earlier, when opium was le- gally cultivated in Pakistan, it was smuggled from Pakistan to Sicily and to France. There were no addiction cases re- ported in Pakistan then. But with the ban on its cultivation in Pakistan, illegal culti- vation continued and several refineries started operating in Pakistan. Heroin ad- diction in Pakistan itself had taken a dan- gerous turn. In 1986, there were about 650'000 drug addicts in Pakistan (National Survey of Drug Abuse in Pakistan, 1986, as cited in Sohail Abbas, 1991).

While the cost of one kilogram of heroin is about Rs. 30'000 in Pakistan, it is about Rs. 100'000 in New Delhi, Rs. 200'000 in Bombay, and sold at $ 100'000 in the United Stated ($ 1 is about Rs. 31). The enormous price of heroin in the international markets led to its il- legal export to the western world through organised drug trafficking syndicates. As the check on the cargo and passenger lug- gage originating from Pakistan has in- creased, heroin has become more difficult to smuggle out directly from Pakistan to western countries. Hence, the India route.

Myanmar borders the four northeast- ern states, Arunachal Pradesh, Nagaland, Manipur and Mizoram. It is reported that there are many heroin refineries and as many as 60 mobile refineries in Myanmar. Smuggling across the border into India from Tamu in Burma to Imphal in Manipur has gained momentum. This has made the entire stretch of northeast- ern states vulnerable. Further, there is also illicit poppy cultivation in this region.

Besides the Golden Crescent and the Golden Triangle, the entire Indo-Nepal border is traditionally an area of smug- gling activities. Most of the cannabis traf- fic from Nepal is done through four cen- tres, viz., Siktal, Raxaul, Jainagar and Bhimbnagar in the State of Bihar. In 1987, Nepal took drastic action against drug traffickers and their abettors, result- ing in a marginal reduction in the inflow of cannabis from Nepal. As a result of all these developments, India not only acted as a transit country but also slowly became a consumer point. The net result was a galloping increase of drug addiction rates.

Although the heroin nodes continue to reside in the Golden Triangle and Golden Crescent, it can also be found along a curve starting from Laos and run- ning through Thailand, Myanmar, north- eastern India, Uttar Pradesh, Madhya Pradesh, Rajasthan, Pakistan, Afghani- stan, Iran and Turkey, then crossing into the newly independent countries of the former USSR, such as Tazhakhistan.

Taking into consideration the alarm- ing increase of crude heroin abuse in sev- eral cities and white heroin injecting practices in the north-east of India, the inadequacies in the laws and India's com- mitment to the international conventions and treaties, the parliament of India in- troduced comprehensive legislation in the form of the Narcotic Drugs and Psy- chotropic Substances Act, 1985 (NDPS Act). Not satisfied with this law, in 1988 Parliament amended it to make it more stringent. It passed further legislation providing for the preventive detention of drug offenders, the Prevention of Illicit Traffic in Narcotic Drugs and Psycho- tropic Substances Act, 1988 (PIT-NDPS Act). It may be noted here that certain states such as West Bengal have not agreed to implement the latter law.

The objectives of all recent laws are to consolidate and amend the law relat- ing to narcotic drugs, to make stringent provisions for the control and regulation of operation relating to drugs, to provide for the forfeiture of property derived from, or used in, illicit traffic in drugs, and to implement the provisions of the International conventions on drugs.

Enforcement authorities

Under the NDPS Act a number of authorities have been empowered to en- force this legislation. In this regard, both Central Government and state govern- ments are equally responsible. Under the act various central agencies, the Customs, the Central Excise, the Directorate of Revenue Intelligence, the Central Eco- nomic Intelligence Bureau, the Border Security Force etc. have been empow- ered to implement the act. Under the state governments, the State Excise, Drug Control, Revenue and Police have been vested with powers for the purpose. The international conventions provide for the 'Special Administrations' and the des- ignated 'Nodal Agencies' for co-operative action in the areas of exchange of infor- mation, providing mutual legal assistance and other connected matters relating to treaty obligations. Keeping this in view, under Section 4 of the act, a central au- thority called the 'Narcotics Control Bu- reau' has been constituted by the Central Government to function as the apex en- forcement and co-ordinating authority at the national and international level.

Offences and punishment

The act declares illegal the production, cultivation, possession, transportation, in- ter-state import and export, purchase and sale of any drug enumerated in the Sched- ule. For heroin and opium offences, the Act provides for a minimum mandatory imprisonment of ten years with a penalty of Rs. 100,000 extendable up to twenty years and a fine of Rs. 200,000. On a sec- ond conviction, the mandatory minimum

punishment would be fifteen years and a fine of Rs. 150,000 extendable up to thirty years with a fine of Rs. 300,000. It also provides for death sentence in exceptional cases. Besides these punishments, the Act provides for the forfeiture of property derived from or used in illicit traffic.

Drug misuse: treatment aspects

The act makes no distinction between a drug addict and a trafficker with reference to punishment except in two instances, covered under Sections 27 and 64-A of the act.

Section 27 of the act stipulates that whoever in contravention of any provision of this act, or any rule or order made or permit issued thereunder, possesses in a small quantity any narcotic drug or psychotropic substance, which is proved to have been intended for his personal consumption and not for sale or distribution, or consumes any narcotic drug or psychotropic substance, shall notwithstanding anything contained in [this Chapter], be punishable

Where the narcotic drug or psychotropic substance possessed or consumed is cocaine, morphine, diacetylmorphine or any other narcotic drug or any psychotropic substance as may be specified in this behalf by the Central Government by notification in the Official Gazette, with imprisonment for a term which may extend to one year or with a fine or with both; and

Where the narcotic drug or psychotropic substance possessed or consumed is other than those specified in or under clause (a), with imprisonment for a term which may extend to six months or with a fine or with both.

Explanation

For the purpose of this Section, "small quantity" means such quantity as may be specified by the Central Government by notification in the Official Gazette.

Where a person is shown to have been in possession of a small quantity of a narcotic drug or psychotropic substance, the burden of proving that it was intended for his/her personal consumption and not for sale or distribution, shall lie upon such person.

The central Government specified a 'small quantity' of drugs as:

Drugs	Quantity (%)
Heroin (more commonly known as brown sugar or smack)	250 mgs.
Hashish or charas	5 gms.
Opium	5 gms.
Cocaine	125 mgs.
Ganja	500 gms.

It follows from this section that if the quantity possessed is even a fraction more than the prescribed 'small quantity', the drug addict will be falling outside the purview of this section, thereby becoming liable to the minimum mandatory sentence of ten years prescribed by Sections 15 to 25 of the Act.

According to Section 64-A of the Act "any addict, who is not charged with any offence punishable under Section 15-25 (both inclusive) or Section 27-A, who voluntarily seeks to undergo medical treatment for detoxification or de-addiction from a hospital or an institution maintained or recognized by the Government or a local authority and undergoes such treatment shall not be liable to prosecution under Section 27 *once* in a lifetime: provided that the said immunity from prosecution may be withdrawn if the addict does not undergo the complete treatment for detoxification or de-addiction".

The interpretation of the provision runs as follows: if an addict is charged with any offence punishable under Section 15-25 or Section 27-A of the act, he is not entitled to claim immunity under Section 64-A. In order to claim immunity under Section 64-A, the person must have been charged only under Section 27 and not charged under the other Sections. Again, the application of Section 27 materially depends upon the quantity of the drug possessed by the addict.

The combined effect of Section 27 and Section 64-A of the act would be that, if the quantity of drug possessed is a little more than the ' small quantity', the drug addict would be treated on par with a drug trafficker as far as punishment is concerned.

Nevertheless, in addition to these limited measures in favour of the drug addict, the act enjoined upon the government to establish treatment centres and to supply narcotic drugs in the case of medical necessity. Thus the act has thrown some light on reformative aspects of drug addiction. To meet the expenditure relating to the treatment aspect, a national fund for control of drug abuse has been constituted.

Summation

This chapter has unveiled certain hidden currents underlying the formulation of policies and introduction of legislation on drug cultivation and consumption in India. The initial British Indian Government's response favoured effective regulation of opium cultivation. Even the enactment of the Dangerous Drugs Act, 1930 was more in response to international pressures and less with local factors in mind. Quite clearly, the law and policy on drug issues reflected in the NDPS Act reiterate a similar thrust and pressure. It is very evident that current legislation fails to take the cultural dimensions into consideration. Article 49 of the Single Convention of 1961 allowed member states to eliminate licit ganja cultivation and consumption in a phased manner within a period of twenty-five years. India ratified the Convention in 1964, thereby binding herself by 1989 to make such practices illegal. These (mainly cultivation) were indeed declared illegal by a number of state legislative acts (like the Excise Acts) throughout the Indian territory even before 1989. Thus, without any attempt of any sort to deal with centuries old cultural practices, the state went ahead and criminalised such practices. All these steps undoubtedly distanced the process of policy formulation from the consideration of cultural factors.

If the NDPS Act were to be enforced in its letter and spirit, millions of our people would need to be put behind bars. As it is, the continued widespread and endemic practice of consuming opium, cannabis and other drugs provides convincing evidence of the unenforceability of the law and, effectively, this is tantamount to large scale *de facto* decriminalisation.

This fact alone unquestionably justifies the need for viewing drug use, misuse and its control from the cultural perspective.

Chapter 4

RESEARCH

Scope of the study

The present study is confined only to the understanding of the cultural perspective of drug use in two districts of Karnataka, Viz., Gulbarga and Belgaum. In recent times, research has focused on the etiology of drug consumption with scant regard to the cultural dimensions. We start with a basic premise that a cultural perspective helps us to reassess the myths of the criminalisation approach and also to debunk dreams of eliminating drug use/abuse.

Objectives

The specific objectives of this study are:

To understand the cultural perspective of drug use in two selected districts of Gulbarga and Belgaum; and

To examine whether legislation against drug use has considered 'cultural perspectives'.

Methodology

Culture is taken here as "the sum total of ways of living built up by a group of human beings and transmitted from one generation to another". For an understanding of the cultural aspects of drug consumption, after detailed discussions with experts in the field, we decided to adopt an ethno-methodological approach to the study. Two investigators were asked to conduct the study over a period of six months. Both were briefed about the objectives of the exercise and instructed to take meticulous care in data collection. Thereafter, they were asked to interact with the people concerned to gain their confidence. It was not a problem as the investigators hail from the areas selected for the study. They observed the local peoples' day-to-day activities with particular reference to drug consumption and related acts. They wrote everything they observed. Periodic monitoring was conducted during the course of the data collection.

Care was taken to see that the gap between observation and analysis was minimized by periodic and detailed discussion with the investigators on their written observations. These discussions include clarifications sought from the coordinator and added explanations to the written observations.

Two Phases of Field Data Collection:

The first phase was devoted to gaining entry and obtaining an impressionistic overview of peoples' views on drug use. Group meetings were held in several villages in the districts of Gulbarga and Belgaum. These meetings were conducted by the respective investigators at different places.

The second phase consisted of a survey of 200 drug users in the selected areas. A purposive and multinodal snowball technique was adopted to recruit respondents for this part of the study, which focussed on two aspects:

a) drug use and
b) drug users' views and perceptions on control and prevention of drug use.

The opinions of the 200 drug users selected for detailed interviews (the results of which are presented in the next chapter) are in consonance with the first impressions gained at the entry phase of our research. However, there is no doubt that had we adopted a proper stratified representative random sample of households to obtain the opinions of the general population on drug use and prevalence patterns, the quality of these area profiles could have been improved. But time and other constraints prevented such a detailed thorough preliminary inquiry.

Views on drug use presented as a part of the area profile here below are impressionistic.

Area Profile

The districts of Gulbarga and Belgaum are situated in the northern part of the state. Gulbarga district is adjoined by the boundaries of Andhra Pradesh and Belgaum by the state of Maharashtra. In both the districts there is a fusion of cultures, in the form of language, food habits, ceremonies and, to a certain extent, socialisation. Six areas in each district were identified which are geographically scattered throughout each district. In the district of Gulbarga, Chincholi, Seram, Jevargi, Narona, Afzalpur and Gulbarga town were selected. Similarly in the district of Belgaum, Murgod, Sankeshwar, Athni, Mudalgi, Chikkodi and the suburbs of Belgaum town were selected.

Both districts have people belonging to various castes and communities like Agasas, Samagaras, Channayya, Gondhills, Devange, Banjara, Gosavis, Kurnbas, Khatiks, Brahmins, Lingayats, Hanabaru etc. Their composition in terms of numbers varies from village to village.

1. GULBARGA DISTRICT

Bangalore is the capital city of Karnataka state, located in the southern part of the state. The district of Gulbarga is approximately 800 kms away from the capital. In Karnataka state, it has geographical borders with the districts of Bidar, Bijapur and Raichur. Gulbarga town is the district headquarters, lying at approximately four hours' drive from Hyderabad, the capital city of the state of Andhra Pradesh. In Gulbarga, the previous glory of the Mohammedan kings is still writ large in the form of mosques, customary practices, socialisation, food habits and observance of various ceremonies. Throughout the district of Gulbarga (more so in the town of Gulbarga) the Muslim population is quite substantial. One unique feature of this district is that of communal harmony. Generally, people of different religious share and respect their counterparts. Urdu, Hindi, Telugu and Kannada are the dominant languages among the people. The establishment of educational institutions (privately managed) covering

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numerous disciplines is a recent phenomenon. The temperature is quite tropical. A profile of the selected areas of the district is given below:

Gulbarga town

Many people in this place deny the availability of and addiction to hard drugs. However, they admit to ganja consumption. Apparently, many do not think that consumption of ganja is a criminal offence. It could be either due to ignorance of the law and lack of local experience of the criminalisation process or on account of a strong social feeling which considers it as part of their lives. A cross-section of the society frankly admitted that enforcement personnel deliberately ignore consumption of ganja. Even the enforcement authorities admit the consumption of ganja but deny the availability of hard drugs. Some do entertain a feeling that the establishment of educational institutions, particularly of professional colleges, might have resulted in the demand for these drugs. However, the general feeling is that Gulbarga is a transit point for the trafficking of hard drugs, either to the city of Bombay or Hyderabad. Some people said that ganja is cultivated in the suburban parts of Gulbarga town.

Ganja consumption is prevalent among certain specific communities, agricultural workers and particularly Sadhus. According to some, there is a likelihood of a nexus between ganja trade and *matka* gambling (a speculative game relating to numbers). One notable feature of this town is an awareness of drugs among many sections of society.

Chincholi

Chincholi is a taluka headquarters, which is nearly 180 kms away from Gulbarga Town. Chincholi is adjoined by the district of Bidar and the State of Andhra Pradesh on the northeastern part of Gulbarga district. It is mostly inhabited by tribal communities, some Hindus and a small percentage of Muslims. Certain parts of this village are forests. The majority of the people are involved in agricultural work. Life in the village is typically conservative and customary practices have a strong hold. Except for facilities for primary and secondary education, Chincholi is yet to go a long way in the educational sphere.

Those who wish to pursue higher education prefer places like Bidar, Gulbarga or Hyderabad. Besides agriculture the local people are involved in toddy tapping, sheep breeding, sericulture etc. *Jowar roti(*a kind of local bread*)* is the staple food, besides rice. Peoples are very hard working. A substantial percentage of the locals derive their livelihood from forest products. Villagers here said that ganja is widely grown in the forest. Some indicated that a large number of locals cultivate ganja for personal consumption. Festivals relating to Lord 'Shiva' and local deities are very popular.

Seram

Seram is another taluka headquarters in this district, which is nearly 120-140 kms. away from Gulbarga town. This village is near the borders of Andhra Pradesh and is close to Hyderabad city. Hindu and Muslim communities, hailing both from Karnataka and Andhra Pradesh, live harmoniously together. In certain pockets, Banjaras and other tribal people are in the majority. Agricultural work takes precedence over other kinds of occupations. Only in recent times have small-scale industries entered this area. Optimal facilities for education are available. Festivals for both Hindus and Muslims are observed with pomp and gaiety.

According to some respondents, the widely grown local ganja is transported to the twin cities of Hyderabad and Secunderabad to meet the escalating demand. People here do not openly admit to the use of drugs in their villages.

Jevargi

Jevargi is a taluka headquarters located in the southern part about 80 kms from Gulbarga town. Its population consists predominantly of Hindus and Muslims. It also has a few Christians. Among the Hindu Gods, 'Shiva' and 'Ganesh' take precedence over other deities. Almost all the Muslim festivals, particularly 'Ramzan' and Bakri-Id', are observed very ceremoniously. 'Holi' is an important festival among the people. Educational facilities up to graduation level are available. In recent times, a substantial percentage of the population has headed to other places in search of a livelihood.

A large number of interviewed people frankly considered ganja consumption as a part of their lives. Some people believe that in recent times it has scaled new heights.

Narona

Narona village is about 80 kms away from Gulbarga town, in the northeastern part of the district, bordered by Bidar district and the state of Maharashtra. Village life is a fusion of Maratha and Kannadiga cultures. In this place also the population consists largely of Hindus and Muslims. Among the Hindus, besides a high percentage of upper castes, tribal communities are also present. Life in the village is quite active. The climate is tropical.

Jowar Roti is the staple food. The 'Holi' festival is very popular. The majority of people are involved in agriculture and commercial crops have gained ground. Tobacco, betel leaf and ganja chewing are quite common. In addition to the local consumption of ganja, the local people alleged transport of ganja to Maharashtra. Quite a few admit cultivation of ganja in Narona. Some strongly defended consumption of ganja in view of its medicinal properties.

Afzalpur

Afzalpur is a taluka headquarters, adjoining the district of Bijapur and 120 kms away from Gulbarga town. In this place the Muslim population takes dominance, followed by Hindus and Christians. In recent times Afzalpur has attracted some small-scale industrial units. This place also richly contributes towards Maratha and Kannadiga culture. Barring a few exceptions, communal harmony prevails. A moderate percentage of the population is involved in agriculture. Reasonable educational facilities are available. Almost all Hindu and Muslim festivals are observed. Like in the other villages, the Holi festival is very popular. In recent times migration towards nearby urban areas has been seen.

People admit to the cultivation and onsumption of ganja. According to ome, people more often simply allow it grow wild. Locals speak about the vailability of other drugs like opium and rown sugar on the borders of Maharashtra and particularly in Bijapur. According to some, the student community of these places is the target.

2. BELGAUM DISTRICT

Belgaum town

Belgaum is the district headquarters, situated in the southwestern part of Karnataka. It is surrounded by the districts of Dharwad, Hubli, Uttarkannada, Bijapur and the States of Maharashtra and Goa. Belgaum is approximately 850 kms. away from Bangalore. In this place, one can see the significant presence of both Maratha and Kannadiga cultures. They have a sweeping influence on food habits, observance of festivals, the socialisation process etc. Belgaum has a large establishment of various private educational institutions. Every year, thousands of students across the Indian territory come here to study. Belgaum is considered to be a political and social hot bed, in view of the border dispute between the states of Karnataka and Maharashtra. It has attracted large-scale industrial investments. Hindus form the majority, followed by the Muslims and the Christians. Among Hindus, Ganesh, Shiva and Holi festivals are very popular.

Many people quite openly admit to the increase in consumption of drugs ranging through ganja, brown sugar and other psychotropic substances. Our interaction with a cross-section of the society quite clearly revealed that the recent phenomenon of addiction is not a native one but is influenced by external forces. It is believed that the high demand for hard drugs is a recent one. However, they admit that ganja consumption is a local habit. The elite segment of society strongly feels that the peak demand for hard drugs is in Bombay and Goa but it is slowly sneaking into this area also. According to them, ineffective enforcement has led to this state of affairs. However, the enforcement dismisses this as a rumour, while admitting to sizeable number of seizures of hard drugs. According to them, the seizures in a sense indicate the notoriety of this place as a transit point.

Murgod

This predominantly agricultural Hindu village is approximately 100 kms. away from Belgaum and is situated in the southeastern part. Public facilities fall far below the average standards.

Some respondents said that there was cultivation of ganja in the village. They strongly defend its consumption as a social and customary practice. The majority of the people say that they have not heard about addiction to hard drugs.

Sankeshwar

Sankeshwar has a quasi-urban life. It lies 120-130 kms. away from Belgaum, on the border of Maharashtra. In recent times Sankeshwar has witnessed relatively moderate industrial activity. Otherwise, much of the population depends on agricultural operations. The population is somewhat dominated by Hindus and, to a certain extent, Muslims. People here speak both Marathi and Kannada.

Tobacco and Ganja chewing is a normal practice. People admit to both cultivation of ganja and that it grows in the wild. They speak much about the occurrence of addiction on the other side of the borders.

Athni

Athni is a taluka headquarters, situated in the northeastern part of the district with borders to the district of Bijapur and the state of Maharashtra. This village is about 250 kms away from Belgaum. It is inhabited by Hindus, Muslims and some tribal communities. Unlike other parts of the district, this village displays a typical Kannada lifestyle. At the same time, Marathi speaking people also have their share of a social life. Among the Hindus, Gosavas, Chennayas, and in the tribal communities, 'Lambani' feature quite strongly.

Tribal communities admit to the practice of consuming ganja, and in a sense take pride in it. They tell many tales of ganja consumption as a part of their day life. Other people, while admitting to the fact of ganja consumption, squarely refuse to see it as stigmatised behaviour.

Mudalgi

Mudalgi, an agricultural village situated in the southeastern part of the district, is nearly 200 kms. away from the headquarters and adjoins the district of Bijapur.

Life here differs much from the rest of the district. Tobacco chewing is quite common. The climate is normally tropical. Educational facilities fall below standard. The joint families system prevails.

Informal interactions with the people revealed stray incidents of ganja consumption and ganja cultivation. There are no traces of addiction to hard drugs. People admit that opium consumption was an age-old practice which has not been noticed in recent times.

Chikkodi

Chikkodi is a taluka headquarters closely connected by road to Maharashtra. It is 140 kms. away from the district headquarters. This place is largely inhabited by tribal communities. For the most part the territory is covered by forest ranges. Belief in the local deity is very strong. The community depends on forest products; they have strong opinions about the medicinal properties of many herbs, particularly ganja and opium. People here are very hard working by nature. Group living is very common. The relatively urbanised town presents a different picture. Educational facilities fall below optimal level. A large percentage of the population consists of Hindus, Muslims and others. Toddy tapping is popular. Both roti and rice are their staple foods. In certain pockets, Maratha culture is quite conspicuous.

A majority admits to the voluntary cultivation of ganja. According to some, the produce from this place reaches across the borders. However, not many mentioned cultivation of opium as a contemporary practice.

PHASE I : IMPRESSIONS

The researchers intensely interacted with the people from a cross-section of the selected villages and towns. These included students, employees, villagers, housewives, enforcement authorities (particularly the police and the excise personnel), advocates, judicial officers, teachers, hawkers and parents. The interaction mainly focussed on their views on drug abuse in their locality. Our queries included information about cultivation, peddling and consumption.

In the process of the interaction, most people informed us that the problem of drug abuse was not acute. Drug use was mainly confined to ganja, which was seldom considered as something violative of any law. Quite surprisingly, even enforcement authorities were of the opinion that normally the act of personal consumption of ganja is always ignored unless one is in possession of large quantities. At the same time, they expressed fears about reported abuses of other drugs by the student community. Many others were of the opinion that cultivation and consumption of ganja had its roots in customary practices. However, they quickly added that prohibitive action is being initiated in cases of cultivation.

Parents expressed concern about the sudden increase in drug abuse resulting from large-scale student involvement. According to them, it is gaining momentum because of external influences. Senior citizens representing the legal fraternity were of the opinion that both districts act as a conduit to other places, particularly Goa and Hyderabad. Normally, hard drugs are transported along these routes, which are considered safe. According to them, local demand for hard drugs like heroin and brown sugar is negligible.

Hawkers indicated that chewing tobacco mixed with ganja is also prevalent. Some gave a plethora of instances of how and why people consume ganja. They mentioned distribution of ganja in the Lambani community during the ceremony of marriage. They also disclosed that this practice is related to the family. If it is not performed, according to them, the families would be looked down upon by society. Chewing ganja as an appetiser and as a medicine was also mentioned.

It our travel during the study we met some sadhus who spend their time near temples singing Bhajans. They held the strong view that ganja smoking enhances their concentration.

PHASE II : RESEARCH FINDINGS

Introduction

As stated earlier, from the written reports, indicators were prepared under the two broad headings of (a) Drug usage, and (b) Perceptions of respondents. Having obtained the broad orientation of the locals toward the use of cannabis, we decided to obtain the views of the drug users themselves, a practice which has been rarely seen in India or even elsewhere. Since the number of ganja users is very large, we set a limit of 200 respondents; their recruitment was selective, depending upon the level of rapport we managed to build with them. We used an interview pro-forma for the detailed discussions with the respondents. The respondents interviewed (N=200) are from Chincholi, Seram, Jevargi, Narona, Afzalpur, Gulbarga town, Murgod, Sankeshwar, Athni, Mudalgi, Chikkodi and Belgaum suburbs.

Results

Majority of the drug users had no education (45%) or completed their primary education (33%). Others had completed pre-university level (12%) and rest did professional courses. They were from different occupational activities. Over 55% of them were from the agricultural sector, a figure which would be boosted by some of the seasonal workers, as might be expected of this rural area, 11% were unemployed and 19% students. Majority of the users have been taking the substance for more than 10 years (61.5%), 27.5% took it for 3 to 10 years and 11% from six months to three years.

Main substance used was Ganja (80.5%), followed by Tidigesic (14.5), brown sugar (1.5%) and seven persons used morphine. It is important to highlight that the majority of subjects (81%) were smoking or chewing ganja and had been doing so for many years. That heroin has entered this community needs to be noted. For three persons the mode of consumption was chasing. It is certainly a matter of the greatest concern to find that as many as eighteen per cent of the respondents were injecting tidigesic or morphine. That is not the case even in Bombay. However, these claim to be occasional injectors and reportedly do not share their equipment. How they reached the stage of injecting these drugs requires further urgent research and the profile of such users needs to be documented. This particular finding requires elaboration as this representation is only (more of less) from towns where medical colleges have been situated. Quite notably high mobility among the student community deserves serious consideration.

Apparently, in Karnataka and some other southern states the use of pethidine from pharmacies is rather widespread. This behaviour also needs to be analysed to see whether it contributes to the spread of HIV. Again, the fact that morphine and tidigesic are used more extensively than crude heroin (1.5%) calls for a serious study of medical practice and iatrogenic addictions. As many as 89 respondents stated that during festivals large-scale ganja consumption takes place. In Gulbarga town, during the Holi festival, bhang and ganja are in great demand. Majority of the users was occasional users, with 20% using the drug daily. Among the occasional users, 44.5% took drugs during festivals, 15.5% at marriage celebrations, 10% as medication and the remaining 16 persons took it during exams and four persons for recreational purposes.

If daily use is taken as a severity indicator, just one fifth of the sample falls into this category, the remainder being mainly confined to usage on social occasions. If drug consumption occurs in social groups, as in traditional societies, the social context exerts a significant

nount of control over drug use and otential for abuse is limited. In our mple over 82% consumed drugs in oups as is the custom in that com-unity. As for the rest 11 persons took alone and 10 persons with their iends. For 15 persons the data on this spect was not available. While con-uming the substance the topics dis-ussed by the users were relating to arriage and family (72%), religion nd social functions (25.5%) and re-aining (2.5%) spoke on sex. On the ther hand, non-group or lone use out-de the ritualistic context (another in-icator of severity) was limited to less an six percent, again indicating that ne drug problem is not severe here.

That a small section of students, par-cularly from professional colleges, use ertain medicines to keep themselves wake to study for examinations is nown. The real rate of prevalence of nis practice and whether such people ontinue to use these drugs, or subse-uently switch over to other drugs or outes of self-administration, or give up he practice altogether after the exami-ations are over, are important areas for urther research.

Among the users the reasons for ganja consumption were family tradition/cus-omary practice (15%), customary prac-ice, religious belief (14.5), medical pur-ose (12%) and 9 % took it because it is good for health. On this aspect for 30% of the sample data was not available and for 39 persons it was not applicable as their drug of choice were hard drugs.

The reasons for ganja use given by the respondents confirm our view that the cultural framework for cannabis use is still firmly in place. That cannabis is physically non-addictive is known. The non-addictive use of cannabis is well borne out in this region, where respon-dents have used ganja for several years on specific occasions for medicinal, rec-reational or social purposes. In the light of these findings, some aspects of our prevention campaigns need to be re-viewed and modified. In case of non-ganja users pressure from friends was the reason given for using drugs. This sug-gested that it would be advisable to fo-cus the prevention campaigns on specific drugs and their impacts.

Over two thirds of the sample (137) felt that consumption was part of life or that there was no life without drugs. The rest dwelt on how drugs affected their feelings, either positively (38 persons) when using or negatively (25 persons) when not. These are the typical attitudes which might be expressed by hardened drug users all over the world, but when seen in the cultural context, where drugs play an important part in social and ceremonial life with apparently few negative consequences, the feelings expressed here cannot be considered clear evidence of problematic usage. It is when drug use leads to the breakdown of social and family life, affects the ability to work, damages the body or the mind, or forces drug users to commit crimes, that the state has to evolve norms. Here we find that cannabis use enhances rather than destroys the social life of the locals.

Perceptions of respondents of the sample of two hundred drug users on various social and legal aspects of ganja use showed that most respondents considered the use of ganja as traditional, customary and not antisocial. Around 72% considered ganja use to be part of tradition and seventeen persons felt their drug use was stigmatised. Among the rest 13 % were not concerned about stigma and drug use. Regarding family reaction to drug use, according to 76% family considered it to be a customary practice, 13 % felt family were concerned about drug and the rest felt family was ambivalent towards their drug use.

On the issue of drug enforcement, 56% felt there is no need for enforcement activities with regard to ganja, 27% said there are no enforcement activities and the rest felt that there were occasional raids or selective enforcement. As per the users (80.5%) there was no harassment by police and 19% said they were harassed to some extent. With regard to cultivation of cannabis, 44% felt it is not an anti-social activity and 56% were silent on the issue. On drug consumption 49% felt it is not an anti-social activity, 44% gave no response and fourteen were ambivalent about the issue.

Most respondents considered the use of ganja as traditional, customary and not anti-social. They did not think it necessary for the law to be enforced against its cultivation or use nor, it seems, was it enforced except in the case of drugs other than ganja or, as said earlier, where a person was in possession of large quantities. Typical drug prevention campaigns using death, symbolised by skull and cross bones or coffins, are certainly inappropriate to prevent the use of ganja, if they can ever be considered appropriate to prevent the use of any substance. The typical responses to questions about their own deaths were "as it comes" and "never thought about it", which illustrates the scant regard given to this issue.

Chapter 5

DISCUSSION

This study has examined the use of drugs in two districts of Karnataka. It was conducted in two phases, the first being a general approach to understanding community practices and attitudes towards cultivation, use and law enforcement, the second, an approach focussed on gathering information in a more structured format from a sample of two hundred drug users.

Two main findings emerged:

➢ That ganja has an accepted traditional place in the fabric of the local society;

➢ That the small percentage of drug use which consists of smoking or injecting drugs such as brown sugar, tidigesic or morphine (addictive drugs which have no roots in tradition) is a matter of concern to the community.

Ganja and culture:

Ganja forms part of the local lifestyle. It grows wild and is also cultivated as a crop. People smoke or chew it as part of celebrating festivals and in marriage ceremonies, or as a medicine, and have been doing so for years. Ganja consumption is not seen as hampering the routine of daily life in any way; it is seen as a socially acceptable part of community practice. In fact, it seems to play a functional role in society, encouraging discussion of marriage, family, religious and social matters. The bulk of the respondents feel that consumption of ganja is like any other routine part of their lives, like taking coffee or tea, or smoking tobacco. Likewise, the majority of the respondents do not perceive the cultivation of ganja as antisocial behaviour.

The general acceptability of these practices is further proved by the fact that the enforcement agencies, for the most part, do not attempt to interfere with ganja cultivation and consumption. This shows the views of the authorities with regard to the legal significance of such practices.

Ganja and the law:

The bulk of respondents clearly opposed the idea of enforcing any law against the cultivation or consumption of ganja, nor did they support any preventive measures in this respect. This is hardly surprising in view of the fact that the respondents were ganja users. However, the cultivation of the cannabis plant for the purpose of ganja, and the possession or use of ganja, was finally outlawed by the Central Government (with certain exemptions which do not apply here) in 1989 by notification in the Official Gazette, as provided for in the original 1985 act. This puts ganja in the same category as charas (hashish) while, in the absence of any state laws to the contrary, bhang remains outside the law.

Other drugs:

A small but significant proportion (19.5%) of the respondents admitted to using tidigesic, morphine or brown sugar. All such drugs are potentially physically addictive and tend to be injected, although in India it is not usual to inject brown sugar. This group merits further study because it is a relatively new phenomenon in rural India and one that could prove destructive to the user, the family and society. Where injecting equipment is used, there are inherent dangers to the users of infection from hepatitis B and C as well as HIV, and of injuries, collapsed veins, abscesses, gangrene and needle dependency. Infections can also pass to the non-injecting community. Where dependency on addictive drugs increases, anti-social and criminal behaviour tend to emerge if the regime prohibits easy access to the drug of choice. The consequences to the user and those with whom he comes into contact can prove to be serious.

Thus, two diverse groups have been identified in this study, one large group of ganja users and growers, who perceive their drug use as interwoven with and supportive of society, and one smaller group, whose drugs are not locally grown and whose drug usage is potentially threatening to society. The growth of the latter group needs documenting and monitoring in order to identify the governing variables. The transition and relationship between the two groups also deserves investigation. Another question which needs an answer is whether and to what extent the 'deviant' group has learnt a general message from their ganja using seniors, namely, that using drugs to alter the state of the mind is enjoyable, but have failed to incorporate the full message, which restricts drug usage to traditionally accepted substances and practices. This again requires further research.

The senior members of the community tended to look outwards for an explanation. Those who expressed concern at the acceleration of drug abuse due to a large scale student involvement, said that the problem was gaining momentum as a result of external influences. The senior citizens, who mentioned local trafficking routes, viewed the demand for 'hard' drugs as negligible but they may not have realised the full extent of their use.

Drug use and problem drug use:

Criminalising drug use has failed to control an upsurge in demand for non-medical drugs in western countries. Instead, it has provided a fertile atmosphere for the black market in drugs to prosper. If bent on introducing laws to control drug usage, the well intentioned legislator should be aiming to prevent 'problem drug use', i.e. drug use as a consequence of which the user experience medical, social, psychological, or economic problems. If problem drug use can be minimised, society and the individual will be protected. But to attempt to legislate against drug use per se is an unwarranted interference in the rights of he individual, unless it can be proved that drug users generally become problem drug users and that legislation is an effective and a humane way to control drug use.

Chapter 6

CONCLUSIONS

A critical perusal of the history of mind altering substances illustrates the way in which societies have considered consumption of certain drugs as a part of daily life. The British were reluctant to proscribe against the production and consumption of opium in view of the cultural uses to which it was put without incurring harmful consequences of any note. Their stance lasted until just before Independence when, under international and domestic pressure, they were forced to take action.

The present study, applying the principals of ethnomethodological research, has brought to light certain cultural and non-cultural aspects of drug use in two districts of Karnataka. The approach adopted has proved rewarding and revealing, inevitably raising nearly as many questions as it has answered.

A critical examination of the prevailing legislation reveals that the initiative taken by the Central Government in the form of the NDPS Act of 1985 was in response more to international pressure than any appraisal of the prevailing domestic realities. If the NDPS Act, as amended, were to be enforced, the prisons of India, already desperately overcrowded, would collapse under the weight of millions of traditional ganja, charas and opium users. The real effect of the act is to provide the law enforcement authorities with further power over the people. The result is a windfall for the corrupt members of the police and for the black marketers. Since the penalties for trafficking in traditional drugs and synthetic or derivative drugs both incur stringent penalties, the black marketer will obviously choose to trade in the most concentrated and profitable drugs. As traditional drugs become harder to find due to the threat that the Act might be enforced, the traditional user will be tempted to shift to whatever other substance is available, either alcohol, heroin or pharmaceutical preparations. After a lifetime of legitimately consuming traditional drugs, a person is not very likely to stop resorting to some mind altering substance. However, on the positive side, most of the states have enacted rules under the NDPS Act which provide for issuing licenses to habituated persons for either pure ganja or opium from government depots at controlled rates and in restricted quantities by way of maintenance and as a step towards treatment. These measures are sensitive to the cultural needs of the community.

This study does not seek to encourage drug use; culturally accepted but addictive drugs like nicotine and alcohol are the cause of more deaths and life threatening disorders than any other drug, licit or illicit. Rather, the study wishes to underline the point that the practical utility of any coercive measure squarely depends on the cultural ethos and customary practices of the people. Prohibition of alcohol was attempted in the USA and promptly gave rise to a booming black market liquor trade run by criminals. Prohibition failed because the culture and workings of society were not taken sufficiently into account. In other words, any coercive measure which runs contrary to the cultural dimensions of a given society is bound to fail. An Act which is impossible to enforce in its letter and spirit, and which is openly flouted in many parts of the country, merely makes an ass of the law, and should be amended or repealed.

NOTES ON ETHNOMETHODOLOGY

Ethnomethodology is a general method of inquiry, used in criminology and several other areas. It does not purport to give explanations or extent of criminality, although application of its methods may lead to greater understanding of these areas. It seeks to give an accurate account of what has occurred or is occurring in any social interaction and to provide a sense of structure for the interactions. Essentially, it is concerned with the study of everyday activities. Its interest is centred on how the individual experiences and makes sense of social interactions.

This type of research, a typical approach, which substantially departs from the existing sociological explanations of human behaviour. The foundations of ethnomethodology have provided a drastic critique of sociological views. They have undermined positivist ideas by challenging the basis on which they sat, and replaced them, with something totally different. Ethnomethodology appears to have hit a nerve because it made many people question whether sociology can be objective and scientific in character.

In many traditional sociological approaches, there is a basic idea that the society is underpinned by a shared set of rules. Some researchers seem to contend that these rules are invisible, in the sense that they are so basic as to be generally understood and accepted without realisation; or they are assumed to be so obvious that they do not require discussion. Often it seems that the only way of examining the rules is to discover when they are breached and to explain these breaches. The structure of society would be threatened unless such breaches were relatively infrequent. This idea presumes that there is a common culture within every society which is so basic as to be acted upon without question, and that the society would tend to disintegrate if its rules were broken so frequently that they lose their common acceptance. Sociological explanations based purely upon the presumption of a common culture are insufficient.

Unlike phenomenology, where everything has to be questioned rather than accepted, ethnomethodology starts from how things are as viewed by an ordinary person, whose perceptions are thus accepted as they appear, and are not questioned. The ethno-methodologists, unlike early criminologists, view the social structure as part of the understanding of the activity. They generally accept that there is a basic structure to everyday life, and that most people's activities in any day are largely predictable or taken for granted. Nonetheless, they argue that since the social structure is understood slightly differently by each individual, no real understanding can come of what has occurred until a given person's views of his social structure, how he views the world, are also understood. (For a detailed discussion of this aspect, see Katherine Williams, Criminology (1991):Blackstone Press, London)

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DRUG ABUSE IN TWO NON-METROPOLITAN AREAS[1]

ntext

The National Addiction Research nter (NARC), had indicated in 1987 t the pattern of drug abuse varies from ce to place; that India is too complex ociety for it to adopt a uniform policy its control. Just as the country is a eidoscope of cultures, drug use and se patterns constitute a mosaic[2]. Drug rs make their own choices upon the bstance and the mode-of intake pending upon what their perception is their respective cultural settings and nditions. Available sparse data on drug patterns in villages across the country events us from making any neralization on rural drug use. We did eliminary exploration of medicinal use cannabis and opium in Gujarat[3].

Field work for the present exercise s done in two districts of Saurashtra gion. Here we outline briefly the status drug abuse in the districts of Porbundar d Junagad as obtained in the early part the year 2000.

ethod

Our *objectives* were to document the pes of abused; to identify whether ltural or traditional factors continue to fluence drug taking behaviour; to find out whether new substances have entered rural areas and to know whether new modes of intake have found favour with drug users in villages and small towns.

We felt that it is *important to study* drug abuse in small towns and villages since the vast majority of people still live there. Data from this large segment of people are important to policy makers. Obviously national policies and programmes will be flawed if they are based on findings from a few occasional studies in metropolitan cities.[4]

We at NARC wanted to document the rural/small town scenario in order to bring the differential findings to the attention of the authorities and to urge them to evolve policies and programmes which are substance-specific; area-specific; culture-specific and mode-of-intake-specific. That is the best way to ensure the money and efforts spent on drug abuse prevention, treatment and care produce optimal results while protecting the rights of drug users and reducing harm to them; to their families and to the society at large.

Sampling of districts and villages within them was been purposive to cover diverse communities. Porbundar and Junagad lie on the Arabian coast very close to Pakistan. We did some interviews in the district capitals and consciously picked villages that lie in different parts of the districts. *An interview guide* was used to elicit data from peddlers of illicit goods which in this State includes alcohol due to prohibition[5] and a semi structured interview schedule was used to elicit data from drug abusers. In all 181 respondents were interviewed on their drug use.

Secondary data was collected from newspapers and popular magazines; and from national crime records reports. Unfortunately, the Annual Reports of the Narcotics Control Bureau do not publish district wise break up of their data.

Main findings:

A profile of drug users is given in Table 1. The highlights are:

- There were 8% women drug users
- The mean age was over 38.7 % which is far above the age of addicts seen in urban areas.
- Though we did not have data for over ten percent of the respondents, it appears that our sample is skewed with mean monthly income of over Rs.7000/-
- Nearly 90 % of drug users were married.

This paper is written by Gabriel Britto, Molly Charles, A.A.Das with the assistance of Bhaskar Jani under the UNESCO-MOST India programme on the ug problem in the context of macro-socioeconomic changes that are sweeping many countries including India. The authors acknowledge the support ven by the eminent scholars and friends, Dr. Christian Geffrey, Dr.Guilhem Fabre, Dr.Michel Schiray and Dr.Carlos Sanchez Milani.

In Kashmir, people smoke opium; in Punjab and Haryana opium is eaten whereas in the desert regions of Rajasthan and Gujarat, opium is drunk. kewise cannabis products are smoked, drunk, eaten as part of food in different parts of the country. Heroin is smoked; chased and injected. Pharmaceutical oducts (Mandrax, Nitravet 10) are swallowed in Maharashtra and in Gujarat; drunk (numerous brands of caugh syrups) by children in northeast India. ombay, Delhi and Calcutta; injected (buprenorphine, morphine, pethidine...) in Chennai, Bhubaneswar, Calcutta, Delhi.

NARC and ISRD, 'Undermining Human Heritage', Seminar - 504,*August, 2001, pp.42-45. See also Charles et al.* Drug Culture in India, *New Delhi:Rawat ublishers.*

However, in the making of drug policy, science/research has had very little link across the world and governments use research data mostly when they are nvenient. To the extent that research findings inform decision making in the field of drug abuse, the majority of Indian studies are skewed by a macro-y bias: the studies among students out in eight cities in 1977 as well as in 1987 were all in State capitals (Mohan D. Drug Abuse among Students *New elhi: AIIMS. The 32 city study too covered populations in either State capitals or in large cities in the chosen States (Singh Hira,* Drug Abuse, *New Delhi: ISD, 1992). None of them had a rural component even for a comparison. In a vast country like ours where about 70 percent of population lives in villages nd a large proportion lives in small and medium sized towns, metropolitan studies alone cannot provide the correct picture for policy makers.*

See Development Resource Center, 'Grassroots Merchants of Illicit Drugs in Gujarat', Seminar - 504, *August, 2001, pp 46-49*

• There were only 1.1 % of respondents who had schooling above 12 years

• As many as 53 % were either farmers or farmhands 25 % percent of respondents owned land.

• Only 18 % of the respondents lived in a joint family

• 1.7 % were members of the village panchayat

Drugs of Abuse

Opium/Doda pani	46
Charas/ Ganja	47
Alcohol	74
Eau De Colon	4
Morphine Fortwin Valium	11
Brown Sugar	7

♦ Alcohol tops the list with over 40.9 % of respondents who were daily users. Over 18 % of alcohol users make it in their own homes and a small percent drinks *Mahudo*[6]

♦ Ganja Charas were used by 25 % of respondents

♦ Raw opium balls were the drug of choice for 25.4 % some of whom were also using *doda pani*[7]. Of the opium users, some stick a small ball of opium under the pallet and allow it to dissolve; some dilute it with water and drink.

♦ Brown sugar is used only by 3.9 % of respondents. As in the early days of brown sugar usage in Bombay, five out of addicts mixed brown sugar with tobacco and smoked in a *chillum* or in cigarettes. Only one had graduated to *chasing* it on a foil.

♦ Morphine and Fortwin are injected in the thigh by 4.4 % addicts and 1.7 % consume valium tablets[8]. Of the three valium users, one injected it.

♦ Eau de Colon is also reported to be used by 2.2 % addicts.

♦ Around 26 % of the respondents (47) reported to be on 'high' throughout the day using one or more of the substances mentioned above and almost equal number used drugs only once a day

♦ Of the eleven respondents who abused pharmaceutical drugs, the one on valium was doped the whole day; three took morphine/fortwin injection once a day and four of them were injecting between 2-4 times a day.

♦ As many as 69% of respondents spent between Rs.1000-3000 per month whereas 11.6 % spent less than Rs.1000 per month. The impact of drug use on domestic economy needs proper research.

♦ Logically, one should expect respondents addicted to pharmaceuticals to spend the least; but we found that only one of them stated that his monthly expenditure on drugs is less than Rs.500 per month. This needs closer scrutiny.

♦ It is important to note that 15 of our respondents had begun to use alcohol before the age of 15; nine had used opium/doda water when they were children. A third of the respondents had begun to use drugs in the age-group 15-20 years. Only eight percent began to use drugs after the age of 25 years. This is an indicator emphasizing the need for country-wide prevention programme for children.

♦ Initiation into drug use varies: eight percent reported that they started on their own, 33 % began with family members; 30 % began with friends and only 11 % were initiated into drug use by peddlers. Thus there is some doubt on the social construct of the 'peddler' if one were to look from the perspective of the drug users.

♦ *Sadhus* and *fakirs* had initiated five respondents in the use of drugs and in three cases, it was the doctor who led the respondents into drug use.

♦ The reasons listed by the respondents for starting to use drugs were:

· To enjoy (17.1 %)
· Caste tradition (14.4 %)
· To maintain business relations (13.8 %)
· To be like others (24.9 %)
· To avoid offending the host (8.3 %)
· To relieve tension (9.0 %)

♦ More than 40 % took drugs the first time in their own homes and 33 % in their place of work. A few mentioned (3.9 %) that their first experience of drugs was in a temple. Five percent took it during weddings.

♦ Nearly 76 % of the respondents stated that they procure the drugs in their own village; seven percent said they cultivate their own ganja. It is important to note that there is high level of brand loyalty among these respondents: 93.4 % never changed their drug. There were only two respondents who shifted from cannabis to brown sugar calling into question the 'graduation theory'. Almost a quarter of the respondents had one more person consuming drugs in their home. Only three respondents said that no one knows about their drug use; in the case of another 13 %, the family members did not know about the respondents' drug use. But the vast majority (74 %) said that their drug habit was known to their family.

♦ More than 60 % of respondents did not consider themselves as an addict and as many as 96 % had not made any attempt to give up drugs.

♦ While 14 % said that all drugs are bad, 18 % mentioned charas to be a bad drug but only one thought opium is a bad drug. Liquor was considered as a bad thing by nearly 65 % of the respondents.

♦ What do the users get out of using drugs? Their responses provide some clue for developing appropriate prevention programmes:

· Keeps me warm while working on the sea (5.5 %)
· Provides relief from weariness, gives good sleep and good appetite (50.3 %)
· Helps me to work better (11.0%)
· Gives me mental peace (6.1 %)
· Makes me feel fresh (9.9 %)
· I get nothing out of it (9.4 %)
· Around 16 % of the respondents admitted to giving drugs to one or more persons as part of their caste tradition,

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[6] *Mohua is a sweet flower; an ingredient in Indian made whisky; a drink made of Mohua flowers has been popular in various tribal areas of India and is reported to be very nutritious.*

[7] *A mild narcotic potion. It is prepared by crushing the dry shells of poppy pods and soaked in water overnight; the next day it is boiled, cooled and filtered with a thin cloth several times and the potion is ready for drinking. Some opium addicts use* doda pani *for self-detoxification in rural Gujarat and in Rajasthan. Some users also soak tobacco with powdered poppy overnight.*

[8] *Suresh Kumar has reported the incidence of numerous addicts injecting a cocktail of buprenorphine, avil and calmpose in Madras city (*Injecting Drug use in Madras City, *Chennai: Sahai Trust, 1995.*

nelp work on the high seas, for oyment and as medicines. Recipients rugs included 14 women, six children ten adolescents.

♦ According to 59.1 % of pondents, drugs are used culturally approved in their tradition and 33.7 specifically mentioned religious tivals as occasions when drugs are nsumed. Marriage, death, birth, tivals are occasions for the nsumption of opium and *Kasumbo* (a cial liquid preparation of opium). It interesting to note that some pondents mentioned that *Kasumbo* d or liquor as being consumed on these casions. This scenario raises the lowing questions:

· Is this the direction that drug users general are adopting across the untry?

· Are we as a society want to replace nja and opium consumption with cohol?

· What are the implications for public alth? These questions need urgent tention.

♦ Only eleven respondents had some rsonal knowledge of medicinal use of ium five of whom mentioned it being eful for managing difficult deliveries. early 70 % respondents said that they ver took drugs in excess. Of those who entioned that took an overdose, entioned the following occasions: arriage, son's birthday, death in the mily, when son met with an accident, hen husband sold her off to another an, after quarrel with parents, etc. Thus appears that from the perspective of e users, grief management is associated ith excessive drug intake. Only one erson mentioned that he took the drug excess on Shivrathri. Thus, we find at the while the traditional social onstruct of drug use seems to have ersisted, there is an emerging construct hose origins need to be traced: is it a roduct of contemporary films?

♦ In their perspective, drug use auses lung diseases including berculosis, abdominal pain, intestinal welling, liver enlargement, and only six entioned death and these respondents entioned alcohol for its reason. This ype of perception brings up several uestions on the way prevention ampaigns are conducted in India. nterestingly over half our respondents said they did not know whether they were suffering from any disease. Seven had respiratory problems (three of tuberculosis), abdominal pain (2), liver swelling (2) and two stated that they have cancer. A little over 63 % of our respondents go to a *Vaidya* or *Hakim* (66.3 %).

Conclusions:

In this brief paper we attempted to obtain a profile of drug users and drug consumption patterns in two districts of Gujarat. In all 181 respondents were recruited from two towns and eighteen villages. We find that alcohol is the main drug of abuse, opium and cannabis continue to be favorite drugs. It is important to point out that abuse of pharmaceuticals in rural areas and in small towns is a matter of serious concern since there is little mechanism to control pharmacies in our country. Immediate attention has to be paid to this since injecting practice has to be prevented in this era of HIV epidemic. Drug prevention programmes need to be initiated in the schools and through other means to reach to all children.

MONOGRAPH 5

Widows of Injecting Drug Users (IDUs)

An Exploratory paper from Manipur

*Manzachin Hangzo**

Introduction

Manipur is a tiny landlocked state in the north-eastern part of India; it occupies only one percent of the total land area of India and is ranked 20th in terms of the total population, which is a mere 20 lakhs (2 millions). It is divided into eight districts, three plain areas and five hilly areas (Table1.1). Manipur is connected to the rest of India and Myanmar mainly by road and has flight connections to Calcutta, Delhi and Gauwahati. It shares a porous border with Myanmar and the national highway # 39 leads directly to the "Golden Triangle", from where 70% of the purest form of illegal heroin is manufactured from opium that is cultivated in lush poppy fields spread over several kilometres. Almost 10 to 20 Kgs. of heroin passed daily in the eighties via Manipur to the rest of India (Source: Narcotic department of Manipur). Heroin available here is white in colour and it is called Thai No.4 or simply No.4.

Women account for nearly half of all new infection in the world today. The number of women becoming infected through their sexual partners and other routes seems to be increasing. Manipur is no exception. The young women of Manipur are extremely vulnerable, as they are ignorant about the HIV virus. Half of the new infections occur to young women between the age of 15 to 24 years as their sexual partners are also within the age bracket of 20 to 40 years. Therefore, there is a possibility that many young girls who get married to HIV positive men will become a widows soon after. This is what is happening in Manipur state and maybe elsewhere.

Rationale of the study

Manipur is the first state in the North-eastern State that rose to prominence, in the- mid eighties, when HIV was first discovered in 1989 among the Injecting drug users .It was assumed that the largest estimated numbers of injecting heroin abusers (between 25,000 to 30,000) comes from Manipur. It is a fact that heroin flows very easily into from the porous border of Manipur and the two highways have direct links to the hub of heroin manufacturing centres inside Myanmar. The border of Manipur was at one time was reported to be literally dotted with makeshifts laboratories set up by the insurgents of myanmar in nexus with the vested interests in Manipur who are also into smuggling drugs in the Northeast. It is also stated that heroin injecting in this part of the world originated in Myanmar and then it spread to Manipur and to the rest of the Northeast. The rate of incidence among IDUs of sero-positivity for HIV in Myanmar is 75%. It is 71 % in Manipur, 63 % in Mizoram, and 69 % in Nagaland (source ICMR Bulletin 1995).

Young boys in the age group of 16yrs to 30 years, were the first victims of heroin abuse. A vast majority of drug abusers are married men. They inject out of curiosity along with their peers; then got hooked to this potent drug. Such Addicts later became dependent on heroin and continue abusing drug till they die of an overdose, of TB, of AIDS etc. Such deaths have serious social and economic implications. The consequences, of which were seen in the form of many young widows in the late 90s. According to the existing NGOs in Imphal, the years 1997-99 witnessed maximum numbers of deaths (1200-2000) among IDUs who were injecting heroin since the late the 80s leaving behind as many widows in the age group 18-30 yrs. Manipur is becoming the only state in India, it is alleged, to have such a largest number of young widows (Source: ISD an Imphal NGO). The Census in the year 2001 would clarify whether this estimate approximates reality or is just a conjecture.

Manipuri women in general are becoming exposed to HIV /AIDS through their sexual partners (such as husband and boy friends). A large number of females are also into injecting drugs and are involved in a growing complex industry of commercial sex, spreading the HIV virus to many more. Women in Manipur are finding themselves faced with the burden of caring for their husbands and sexual partners who are ill with AIDS. When they become widows, they experience a lack of economic /emotional/social supports from the in-laws. In some cases, their children are taken away from them and are looked after by their husbands' families. This gives them theoretically the option of remarriage by their families.

These young widows are already stigmatised, and victimised by society, Some widows resort to commercial sex or continue to have multiple sexual partners. Since this is a clandestine activity, it puts their sexual partners at the risk of contracting HIV infection. Such behaviour further aggravates their health because they themselves are liable to contract several diseases from such sexual partners (sexually transmitted diseases, Hepatitis B, Tuberculosis...Such comorbidities have adverse impact on their health, economic and social condition.

Purpose of the study

This is a short exploratory qualitative research undertaken with a view to find out the experiences and needs of widows who are affected by HIV/AIDS.

The objectives of study are to:

- Describe the socio, economic and psychological problems faced by the young widows who are HIV positive and who are burdened with small children
- Identify the coping mechanisms adopted by the widows who are HIV positive
- Document the community's per-

**ActionAid India, Bangalore*

tion of these women

- Find out rehabilitation strategies opted by the NGOs and the impact unselling has on these women in anging their lives.
- Indicate specific care need of these dows
- Verify the significance of the "Role Self Help Groups" as tools of em-werment for them.

nportance of this Research

Research, information and education out socio-economic aspects of reha-itation of widows based on a different vironment such as the Northeast will ovide important findings, which can be corporated when dealing with widows HIV positive men for the whole coun-. There is a great need to undertake in-vative research and documentation in e fields of HIV/AIDS for various NGOs, nding agencies and for different sections the community, which are likely to be fected. This study was undertaken be-use ActionAid feels an urgent need to elp the marginalised and vulnerable oups of the society, such as widows of DUs. ActionAid is dedicated to helping e poor and the marginalized and the esent study indicates that the problems ced by these widows in Manipur are nique in nature requiring urgent attention such philanthropic bodies.

Findings of this study will be made vailable to policy makers, NGOs and nding agencies and hopefully, will go strengthen the hands of the Government nd other funding agencies in supporting nd implementing programmes and/or for dvocating policies for women especially he widows of IDUs who are HIV +. The utcomes of the present study will assist n developing an appropriate intervention trategy to address the needs of women ffected directly or indirectly by the HIV pidemic, especially the widows of the DUs and their children.

Sampling :

For the research two urban areas were elected : Imphal and Churachandpur. A few women (29 in number) from Katching District were also included as they were serviced by an NGO. The Table below presents some basic data on the two districts.

Basic Data on Imphal and Churachandpur Districts

Variable	Imphal	Churachandpur
Population	7,07,184	2,03000
IDUs till Sept 1999	10,000-15,000	8000-10000
Estimated numbers of widows	1200 to 1500*	200 to 500*
# of widows getting aid from NGOs	Around 250*	None so far*
Dominant tribes of or people	Meitei Hindu and Meitei Muslim and also Kuki-Chin-Naga tribes (in small numbers)	Kuki-chin lushai tribes
Religion	Hindu/Muslim	Christian/Jew
Race	Tibeto-mongoloid/ Aryan	Tibeto-Mongoloid/chin

**Source : NGOs in Imphal*

The reasons for this purposive sampling of the towns were :

- They have the largest numbers of drug abusers
- They represent the valley and the hills : Imphal is a valley while Churachandpur is in the hills.
- They include the two major religious groupings of the State : Meitei are Hindus and they dominate Imphal while the Paite/kuki/Chin tribes are Christians and Churachandpur is dominated by them. Thus both the communities are included in the sample.
- They include broadly the economically better placed and the poor segments of State. The widows of Imphal are financially more advanced than the widows of Churachandpur. The majority of widows were however were poor especially in Churachandpur where employment opportunities are sparse.
- The two national highways (NH # 39 and 53) transverse through these two towns which also serve as drug routes and have direct connection to the "Golden Triangle " through which No. 4 heroin is smuggled to these two places and elsewhere. Heroin is easily available in these two places (There are well-marked zones where heroin can be purchased without police hassle such as Checkon and BOC in Imphal, while in Churachandpur, New bazaar and in areas around the movie theatre).
- They have the maximum number of injecting drug abusers, as compared to the other districts of Manipur.
- They have the maximum number of drug peddlers who cater to heroin abusers
- They are important business centres when compared to the other parts of Manipur.
- The largest concentration of widows of IDUs are found these towns. This is probably because many young IDUs especially are coerced by their mothers to opt for marriage hoping that marital life will keep them away from drugs. Seven respondents of our study reported that their husbands gave up heroin upon marriage and took to alcohol instead.
- Both have a large number of displaced people due to ethnic clashes between Kuki- Paite in June 1997 and Kuki -Naga since early 80s. When the ethnic clashes took place between the Naga and the Kuki in the early 90s, many Kuki refugee took refuge in Churachandpur districts but when the clashes took place between Paite and kuki in June 1997, many Paite family and kuki fled to the valley of Imphal which was relatively safer for them. People here are more receptive and open to outsiders than in other parts of Manipur.
- Over the years these two cities has seen many floating population, Bangladeshi refugees, Bihari labourers, Burmese defectors et al. and such people are invariably without families which puts them at risk.
- The recent ethnic clash in Churachandpur town (June 1997 till October 1998) has disrupted normal life. Many poor families are displaced from their homes. Unable to feed and maintain their families, widows and many young girls go in for Commercial Sex Work (CSW). This furthers makes them feel guilty (as most are Christians and believe that prostitution is a sin). Thus the intake of drug among those young

girls increases. Generally because of this HIV is also prevalent among these women. so far no concrete programmes have been formulated for widows and women in Manipur.

❒ Both have several NGOs working with issues connected with HIV/AIDS that deal mainly with IDUs which is not the case with other towns.

The wards or areas covered for this research in Imphal are indicated in the map. The specific locations were :
Thangmeiband, Sagolband, Uripok.
Lamphelpat, Nagamapan and, Langol.
Singjamei, Yaiskul, Langnthabal and Thonju.
Kwakeithel, Mayaikoibi, Ningthemkol.

In Churachandpur, practically the whole town was included :
Upper Lamka
Lower Lamka
Mual Veng
Rengkai Road
New Bazaar
New Lamka
Zenghang Bazaar
Besides, some respondents were recruited from nearby villages such as Phailian, Hanglep, Mission compound, Bungmual, Pearsson Muan etc.

Sampling of respondents :

It was reported that there are around 1200-2000 widows of IDUs in Manipur. We decided on a quota of 250 widows to be interviewed. In the end, we ended up interviewing 280 widows. But the report presented here is based on information provided by 255 widows only since 25 of them did not want to be included in the research but were willing to discuss. This happened for various reasons such as their economic status, etc. An attempt was made to cover as many segments representing various demographic variables such as of place of residence (rural/urban), economic condition, social status, religion, tribes, caste etc was also be taken into consideration

The respondents in Imphal were recruited from among the participants of the self-help groups of widows initiated by some NGOs. In Churachandpur, there were no specific programme conducted by the NGOs to benefit the widows of IDU. The number of respondents with the help of NGOs in the two districts are given below :

Name of NGOs	Respondents
(Social Awareness' Service Organisation. SASO	12
Integrated women children Development organisation. IWCDO	8
Continuum Of Care Project (COCP)	21
-COCP Kakching district project	29
Institute Of Social Disease - ISD	56
Life line Foundation	38
Centre For Social Development- CSD-	36
Widows in Lamka rehabilitation & research centre. LRRC.	26
Shalom	29
Total	255

The functioning NGOs in Churachandpur has no specific widow's Programme. Two NGOs, Shalom, and LRRC have a Programme working with the female heroin injectors who also undertake commercial sex.

The respondents' selection was also purposive. While attempt was made to ensure that various segments of widows were included in the sample (as can be seen from the profile of respondents given below), only women indicated by the NGOs and those who were willing to be part of the study were included. Our sample included only the accessible subjects. Many young widows of rich families refused to participate in this research. Their powerful parents and in-laws were against exposure of these women.

A Profile of Respondents

VARIABLE	*FREQUENCY*
Age of Respondents :	
• Below 24 years with no children (hence with greater probability of a second marriage)	50
• In the age group 25-30 years	180
• In the age group 31-35	25
Religion :	
• Hindus	60 %
• Christians	30 %
• Muslims Continuum of care initiated project self-help Group of (Involvement of the Community for Human Eempowerment-ICHE) and CSD provided these contacts.	5
Economic Status (stated income per month) :	
• Between Rs.300-500	70 %
• Between Rs.501-3000	20 %
• Above Rs.3000	5 %
Educational Status :	
• Illiterates	25 (10 %)
• Primary education	128 (50%)
• Upto 9th Standard	50 (20%)
• Completed High School	26 (10 %)
Place of Residence after Widowhood :	
• Staying with in-laws	90 %
• Staying with parents (These are usually very young widows with one child and her parents are well to do people).	10 %
Employment Status :	
• Petty business- paan shop, tea stall, small hotel, vegetable sellers, street vendors, loom weaving, wool embroidery, block printing, pickle making, jam making house maid, - self employed	(50 %)
• Government jobs (Nurses, teachers, clerks in Gos)	(2 %)
HIV Status :	
• HIV positive	50 %
• HIV negative	40 %
• People living with AIDS related diseases	10 %
Mode of marriage :	
• By elopement (the norm in Manipur; post elopement, priests and pastors bless them).	
• By abduction	7 %

Research design :
Since there is no prior study in the country on the subject, ours has adopted an exploratory design.

struments :

To collect primary data, in-depth in-rview guides were used for individual terviews with widows. Based on the in-rmation collected, case studies were veloped. Each Household was revis-ed twice-or thrice to invite them for the cus group meetings. If they refused to ome, then they were taken up as sub-cts for "case studies".

Case studies from a rehabilitation ome*(Sneh Bhawan) was collected to ubstantiate on how to build up strategy or rehabilitation for these widows after ompletion of data analysis in Manipur nd we hope these insights will be use-ul. Sneh bhawan is the only women re-abilitation centre in Manipur. It was tarted by Salesian sisters as a branch of ne school "Little Flower " a catholic in-titute. This centre was open to meet the eeds of female IDU and later for desti-ute young women who were inflicted vith AIDS.

Key informants were contacted from mong the personnel of the NGOs, pro-essionals, peer educators, outreach vorkers, social workers, church leaders, vomen's society etc. Doctors from STD linics, AIDS hospice (Shalom has open one centre for the terminal ill AIDS pa-ients for both male as well as female in Churachandpur with a 40 beds capacity). Two major hospitals (RIMS & JN hos-pital) that dealt with IDU and HIV, plus one physician responsible for AIDS Management (PRAM) were interviewed in depth.

Personal in-depth interviews were held with 10 members of the families of the respondents (mother in laws- broth-ers in laws, sister in laws and sisters etc.).

Focus Group Discussions(FGDs) with them spread over 31 sessions (5 in Churachandpur and 25 in Imphal and one at Kakching which is about 55 Km from Imphal.). These FGDs were held in small groups consisting of 12 to 22 widows' respondents grouped according to their age. These discussions were moderated by the consultant and the Principal In-vestigator with a listing of issues to be covered during the FGDs. The interviewes was administered in local languages, "Meitei -lon" for Imphal and Kakcking areas and Paite, Hmar, and Kuki, which are the common languages spoken and understood by the people of Churachandpur areas. Widows belong-ing to the higher income groups were not a part of the "self help group" and were not interviewed. Thus the peer workers of the NGOs recruited the subjects spo-ken to. The lower income group partici-pated in the hope of getting some forms of help (financial, emotional, medicine). During each of these visits, the issues pertaining to the widows were ascer-tained and solution was sought if pos-sible during the course of the sessions held. FGDs were held at the convenience of the widows, at their place of choice. The issues explored, were, coping pat-terns; the issues based on economic, so-cial and psychological aspects of wid-owhood in youth. Some shy widows' preferred individual in-depth interview while bolder talkative ones preferred FGDs. Sentiments and feelings of these women were taken into consideration and certain emotional issues were tackled sensitively. The issue on whether they were HIV positive was never brought in the open, only 10% disclosed their sta-tus, and some in the course of the dis-cussion came forth spontaneously. 5% of the older widows were quite ill, and were on treatments for TB, 2% even missed their second or the third time "focus group discussion" due to serious illness or some health complication. A commu-nity focus group discussion with Five family members of IDU was also con-ducted in five different localities of Imphal.

Case Studies:

Some case studies will highlight the sufferings of women who were married to male IDUs and later abandoned by them.

Case study "A"

"A" is twenty-six years old female IDU, from Chandel district (South east of Manipur) seeking rehabilitation for her injecting habits at Sneh Bhawan in Imphal town. She has been abusing heroin since the age of fifteen. Her boy-friend initiated her into the drug habit then. She got married to him when she was sixteen, had a son at seventeen and got divorced a year later. The main rea-son for the divorce was that both were abusing heroin together and had constant fights besides they belonged to different religion and caste. He is a meitei Hindu and she a Naga Anal tribal. (Though in-ter-caste and inter religious marriage take place in Manipur, it was frowned upon by elders, specially in the case of IDU who are considered as parasite by fam-ily members. There are examples of many IDU marriages failed because of family pressure. Family finds it hard to support their IDU son who is still depen-dent on then financially. Moreover a wife become an additional burden.

"A" comes from Chandel district that has direct connection, NH # 39 which passes through her village to Moreh town (border nodal town between India and myanmar) where heroin is easily avail-able and is an hour by bus. She belonged to a large farming family, with many other siblings' three elder brothers and three younger sisters. Two brothers are dead, and one died due to excessive abuse of alcohol' and the other due to malaria epidemic in 1994. Sisters are not abusing drugs. Father in his sixties and mother ailing. Chandel's economy re-volved around from paddy cultivation and selling of firewood

Habits and attitudes while injecting

"A" started with sniffing smack and after one-year the effect wasn't good enough so she decided to inject heroin which gave her a better "kick". The first "kick" she got when she injected heroin gave her a feeling of euphoria and ec-stasy. She was married then and all she cared for those days were heroin. Even when she got pregnant she continued in-jecting heroin and gave birth to a normal male child. But even the birth of her son did not stop her from continuing her in-jecting habits. The tragedies in her life, her divorce and her brother's' death made her want to inject more in order to forget her sorrows. She was always depression.

She became careless and started hav-ing a negative attitude towards life think-ing her life was over. Her irresponsible behaviour and casual attitude landed her in jail when she was 20 years old for thefts (around 1994), her son was just two and half year old living with her parents. After she came out of jail she started liv-

ing in Imphal town where she indulged in heroin peddling in order to sustain her addiction.

She used to inject at least 6 to 7 times a day, each of 2 milligrams. She buys 40 grams and out of the profits she managed to get at least 10 grams worth of heroin to be able to last her many days. When she doesn't get her daily quota of heroin she suffers from withdrawals and many ailments like cough, tears in her eyes, bodyache, running nose, joint pain, listlessness and this makes her craving for heroin very strong.

In order to sustain her injecting habits, as she is unemployed. She used to steal rice stored at her barn, chicken from the coop, her sister's clothes to pawn them, and sometime she used to go to the family farm to collect maize and cucumber, sell it at the vegetable market and go buy drug with the money. She went to the forest to collect firewood if she had the strength and got good money for it.

Injecting habit

She used to share injecting equipment's i.e syringes and needles with her male IDU friends who are also injecting heroin. Most of the time they do not clean it properly as they are in a hurry. She was the only female injecting heroin from her village and many people looked down upon her. Her reputation was bad, she was considered as sexually promiscuity and even the underground militants gave her a warning to give up drugs or else she will be shot death. She has many boyfriends because she wants to forget her sorrows in life and also practices unsafe sex with her sexual partners. She doesn't want to marry because she is aware that men don't like to marry IDU woman with a small child.

Rehabilitation Process

"A" enters "Sneh Bhawan", an all women rehabilitation centre located at Imphal. The reason that compel her to seek such drastic change were the following : By 1998 "A "had become a core drug addict with no hope. She was 25 years. Her parents and her brother and his wife were totally fed up with her erratic behaviour. Her son was 11 years old and militants warned her and her family to change her lifestyle. She was warned repeatedly but she never listened to them .She thought being a woman IDU she was relatively safe. The militants then threatened her family. Her younger sisters were growing up and she was considered a bad influence. Her brother decided to give her up to the underground militants to take action against her. Many of her male peers who used to inject with her were killed either by AIDS or by militants. Hence in April 1999, her brother forcibly brought her to "Sneh bhawan". She said she was not interested in rehabilitation and underwent a lot of suffering during her detoxification period that lasted for fifteen days . After her one-month she ran away from Sneh Bhawan. (This centre has a six months rehabilitation course). Her brother caught her hold of her and beat her till she became unconscious. She was hospitalised and a Salesian sister (an order of catholic nuns) came to visit her and assured her of a place again in Sneh Bhawan. It was their kindness and compassion that made her returns to rehabilitation centre to try and change her life for the better.

Future Plan

"A" is willing to change her lifestyle, if she can fully give up heroin addiction. When she is inside the "centre", she feels strong, protected and motivated. But once outside in a hostile surrounding, she is not secure. She wants a different life, a total change if it is possible only if she is economically independent and can find a job. Otherwise even after her six months of rehabilitation Programme she fears she will easily relapse back into her old habits, She feels that women like her have no choice in life. She dreams of being reunited with her husband but the chances are remote. He is a drug addict himself, unemployed and from a different community. He has no means of supporting a family. Her wishes in life have not been fulfilled and she feels deprived of everything. Therefore she is bitter and likely to go back to her old ways.

Observations:

"A" is mentally very disturbed after she knew that she was HIV positive. After she joined Sneh bhawan she was counselled and she agreed for an HIV test. The post test counselling was done and she even joined the 'Manipur network of positive people'. She had an exposure when she was chosen to represent the Manipuri women who are HIV positive , for the first time in the first ever Indian network of positive peoples (INP +) workshop held in august in Delhi. She is aware of her status and has faced it with lots of acceptance and understanding. She has grasped the effects it would have on her and her responsibilities, not to put others at risk. She is worried because she has put others at risk while she was unaware.

Therefore she suffers from some depression and her frame of mind is still not normal. She is paranoid about the safety of her family. She worries constantly about her son .Her greatest guilt is that she fears that she may have passed on the virus to her mother because she had often clandestinely used her mother's hypodermic needles and syringes for injecting heroin washed it afterward with plain water and place it back. Her mother is ailing at present. She is also worried about her unmarried younger sisters and wants to teach them about safe sex.

She needs emotional and psychological support from others. It is good she joined the network of positive people in Manipur.

Case study "B"

Personal History:

"B" is a 29-year-old injecting drug user. She is married with two kids and her husband is also a drug abuser. She was initiated into drug only after her marriage him who was already on drugs. She tried very hard to change her husband but could not do so, then she joined him and got hooked to heroin. This is also and inter-caste-religious marriage; she belongs to the tangkul Naga tribe while he is a Meitei Hindu. She started abusing drugs in 1993 one year after her marriage when she was 22 years old. Her husband, who is 34 year old, has been abusing drug since he was 17 years old. She was married during a short period when he was free from abusing drug. He was clean for two years but since he has two other brothers who were also abusing heroin he relapsed soon after and later even his wife joined him. Together, the

mily pooled in whatever money they ad to buy heroin and injected together ut did not share the needles and sy- nges. One brother died due to compli- ation, arising out of drug abuse. One of nem used to steal other's injecting quipment's, Thus unknowingly they nared. Her husband's family was very ch family and her husband had studied n Pune. Her two-brothers -in law despite eing drug addicts, were sent to Mumbai or further education. Her father -in -law s an alcoholic; mother-in-law is a pan ddict. The whole family is addicted to ome form of chemical substance.

Background:

"B" is literally an orphan, her father lied when she was just two years old eaving her and her four year old sister. They became a destitute because soon after the death of her father, mother re- married. Her grand parents brought them up. She studied only till class 10, as she was not interested in higher studies. She got married soon after. She was not aware of her husband injecting habits at the time of her marriage. According to her, he was very smart, spoke good English and she was impressed and without knowing him well she elopes with him. At the time of her interview she got two children they were 5 and 3 years old. Later when she found out about her husband's habits, She wanted to divorce him but she had no home to return to. Her grandfather was dead and her grandmother was with her mother, who had children of her, own. She hardly bothered about "B". Her elder sister is happily mar- ried and had two children. She is not too fond of her "B" on account of her drug addictions. Whenever "B" goes to her village, people touch her and feel her to see what it is like to touch a drug addict and she is the centre of attraction. Hers is a remote village in north district of Manipur and people there are very ignorant about drugs like heroin, though rice wine is common.

Habits and Attitudes.

She got into drug use due to unhap- piness in her marriage. She got married to escape her unhappiness and sorrows but she felts sad after marriage since her husband was totally useless and jobless. His main occupation was with looking trendy. Once she got hooked to heroin, all she cared for was her daily quota of heroin. She used to be very restless whenever the craving for drug become intolerable, she used to ask money from her husband grandfather on the pretext that she needed to buy milk for her baby. She shamelessly borrowed and begged for money from rich friends many times. Sometimes she used to sell expensive items from home. She and her husband sold all her gold earrings and bangles in order to sustain their habits.

When intoxicated with heroin, she used to sleep the whole day, neglecting her children. Her daughters looked after themselves, if there is no food then they go to their neighbour's house to be fed. Her younger daughter who is very bright would say that her mother is having her drug induced sleep and she has not eaten, so she neighbours would feed her.

"B" used to beat her children out of frustration if she could not get her daily supply of drug and her daughters were afraid of her. She used to fight with her husband and his brothers over the sup- ply of drug creating Her in-laws were fed up of her behaviour. Being a mother and women, she is disliked by all because of her injecting habits and she was made to divorce her husband. Men injecting are still tolerated but injecting females are not tolerated at all. Her attitude was care- less and her concern during this period was just to get her daily supply of heroin. After she injects she used to become ul- tra active; do her daily housework and then go into a deep sleep. She tried mak- ing herself decent looking but did not need much effort, as she was already very pretty. Hence men approached her for sexual favours and she accepts them be- cause they buy her heroin. She was not worried about her reputation, as she was a heroin addict and a divorcee. Her el- der daughter was taken away by her hus- band 's family.

Rehabilitation.

One year after ""B" was divorced, her physical and mental condition deterio- rated so much so, that her elder sister got worried. She asked around and found out that there is a home for female addicts called "Sneh Bhawan." Because of her sister's persuasion and the little baby girl whose cheerful manners motivates her mother to take this drastic step to change her life. "B" entered rehabilitation Programme with a hope for a better fu- ture; her baby daughter accompanied her. While in rehabilitation centre she suf- fered during detoxification as she was giving up drug after seven long years of abusing heroin. Till today, if the weather is a bit cloudy she suffers from joint pain and frequent backache but she enjoyed the lessons and the vocational training provided to her. She likes tailoring and knitting.

While at the rehabilitation centre her ex- husband visited her frequently trou- bling her and asking her to hand over her younger daughter but the salesian sister are taking good care of her and sending her to a nearby school for free educa- tion. This insulted the husband's family, as they fear that the child will be con- verted to Christianity and she will be lost forever after her death. She is a Chris- tian and would like to have a Christian burial. She is symptomatic and not likely to live long.

Future Plan

"B" has given the Salesian Sister the full responsibility of educating her baby girl. Till the time she is healthy, she wants to be self-reliant economically and lead a productive life.

Observations:

"B" discovered that she is HIV posi- tive only after she came to "rehabilita- tion centre". Hence she is very unhappy knowing that her chances of surviving long are dim. Her husband did not sever his ties with her and she is still emotional attached to him. He too is HIV positive and she blames him for passing the virus to her. She feels victimised by all the trag- edies she suffers in life. She is full of anger and fights constantly with the other females' inmates and cannot get along well. She has talents and good skills for tailoring and knitting but she is lazy and get tired very soon. She is unable to fathom such a tragedy and mentally has not accepted her status. She wants to re- form and lived again with her husband after she gets rehabilitated. She is vul- nerable and very dependent on others for her emotional security

Case study "C" :

Personal History

"C" is a 28 years old married female drug abuser who abuses chemical substances. She hails from Churachandpur town and had been in for rehabilitation for at least four months at the time of interview for this study. She had not inject heroin at all She is a mother of three children her eldest son is 6 years old, daughter 3 1/2, and younger son is 1 1/2, years old.

She married a much older man who is not a drug abuser and who had a lot of patience in dealing with her bad habits. Her family consists of her widowed mother too.

Her background:

"C" has just one widowed mother. Her father passed away when she was just one year old. Her mother returned to her parent's home Thus she too came to live with her grandparents. They were well taken care off here and her mother never remarried. She had everything she need and she was given a Convent school education at "St Mary's". It was while at this boarding school that she was first introduced to drug called phensedrly a potent cough syrup, between two girls, a bottle of phensedry was shared. She liked the drug because it loosened her inhibition and she could mix around more openly. Otherwise she was an introvert and very shy. She dropped out of school after 10th and refused to continue further. It was then that she got into full time drug abusing because she had plenty of time to kill, besides drug she go for movies intoxicated along with her female drug addicts her mother had no control of her.

In order to stabilise her life, her mother encouraged her neighbour, who was still a bachelor at 38 years, to court her. She used to insult and rejects him whenever he came and never sat with him but slowly his mature behaviour and kindness won her over and at 22 years of age she married him. He is aware of her drug addiction but since he doesn't abuse drugs, he thought he would be able to reform her.

After her marriage she gave up drugs because of respect for her husband and till the second baby was born she was clean. Moreover after her marriage in 1993, the drug she was abusing became very scarce and it literally vanished from the market. The militant called a ban on sale of cough syrup "phensidryl. Unavailability of drug, combined with motherhood and regard for her husband made her abstinent.

But after second baby was born, she had some discord with her husband, she got angry and stopped breast feeding her daughter, then she tried out a new drug called spasma prosovon "SP", at the suggestion her neighbours. She was already suffering from physical ailments and the pain was unbearable for her, plus her craving for drug was too intense, so she bought drug worth Rs2000 and started abusing "SP". According to her, her mother and husband were afraid of her violent temper and could not control her. She behaves irresponsibly behaving like a teenager, going for movies, drinking and roaming the whole day while her mother takes cares of her children.

Attitudes and habits

"B" was on and off drug for quite sometime. When she was off drug she suffered much physical pain, which vanished after a dose of drug. It electrified her and made her feel alive. But even when she was off drugs her longing never went away. It was craving for the euphoria and " kick " she got from drug. She had no other more pleasurable experience .She was clear that she would continue to abuse drug since it gave her immense pleasure. Equally she continue to perform her duty as a wife and a mother. None the less she neglect her children she used to go off in search of drug .After she get her daily dose she sleeps and neglects to do the housework too. Her main source of income comes from husband for household expenditures Bu t sometime she squanders away some amount for her drug, sometime he refused to give her in such situation she sold her gold, clothes or." Puan". Puan is a kind of wrap around worn by ladies of Manipur. The quantum of her intake of drug depended on the amount of money she had, if she had she buys if not she take on credits. There were times when she went without any drug but then she substituted it with alcohol.

"C" goes in for rehabilitation

She suffered due to her addiction and her husband was also losing his patience. She had been abusing drug for nearly eight years. Her elder son was growing up and her mother was ailing too. On the persuasion of her grandfather, whom she adored she decided to go in for rehabilitation to reform her life. By then her family life was in a shambles and the harmony in her marital life was gone. Husband was at the end of his tethers and she was afraid that he might leave her for another woman if she continued to behave irresponsibly. Her behaviour had alienated her from her son and husband and she was ashamed of herself. Her main motivation to change were her growing children whose lives were getting destroyed and she want a better future for them. At Sneh Bhawan she misses her family but she was happy that she was there to change her life. She wished she had known about "Sneh Bhawan " earlier. Her husband has given her another chance and did not even suggest a divorce. She is happy here and hopefully completes her six-month course of treatment

Future plan

"C" was quite good with her hand and at wool-knitting and loom work. Besides she is still young and healthy .In order to repay her husband of all the money she had wasted all these years, she planned to buy a knitting machine and start knitting woollen garments and sell them. She wanted to start a small business to keep her mind busy. She was serious about changing her mind. She wished to take proper care of her husband and children so they do not resent her for her past behaviour.

Observation

"C" is one of the lucky few who have a chance to turn her life around. She was young and is HIV negative. She has no mental depression. Post drug days she did feel physically tired, but with lots of love and good nutrition she can rebuild her life. She has a strong prop in her loving husband and a supportive mother. She can be easily rehabilitated for a better life.

Study "D"

Personal History

"D" is a 25 years old widow. Her husband died of AIDS in February 1999. She has a five years old now. She does not inject heroin or abuse any other drugs. Currently, she is employed at a NGOs as peer outreach worker earning Rs 800 a month as part of a widows' Programme. She got employment after her husband's death because the NGOs used to provide home based care for him while he was sick. Because of her extreme economic hardship she was given the job. She chose and continued to live at her mother -in-law's house. Her mother-in-law is a registered nurse and was the third wife of a powerful man. Her husband family consists of seven children, four sisters and three brothers; one died of AIDS and the elder one is an alcoholic, the youngest son is free from drugs. None of the girls abuse drug, one is married, one is a nurse and two are in college, "D" has emotional support from the women folk of her household.

"D" got married to her deceased husband after knowing him for just a week. She was not aware of his addiction and he was courting her elders who got married to another man. He was upset and emotionally blackmailed this young naïve girl. Out of sympathy she agreed to marry him. She was just eighteen and was impressed by his well spoken English and he told her that he studied in Chandigarh. But that was a long time ago and he has been abusing heroin since the late 80s. He was in and out of de-addiction centres. She found out about her husband 's addition to heroin only after she married him. But, by then it was too late. There was no alternative but to make the best of her marriage. She tried to change him but he could not give up heroin. She had no choice. She belonged to a very poor family and she so could not go back to her parent's home with a small child. Her sister in-law would not welcome her return. She had cordial relationship with her mother -in-law and she is happy to stay with her.

Her background

She studied only unto class five and dropped out of school, as her parents were poor. Mother is a vegetable vendor and father has no employment. He does carpentry work whenever he gets assignments. She has eight siblings, four sisters and four brothers. Only the eldest brother is working in a government job. All her Sisters were married. They lived in an urban area and have no scope for farming and cultivating.

Husband illness.

Even after seven years of marriage, her husband, who was a hard core addict did not give up injecting heroin except for a few months while he was at a de-addiction centre. He continued to abuse heroin till august 1998 when he fell seriously ill. Even when he became slightly better, he abused alcohol because of bodyache. By then he was suffering from meningitis and had constant headache. From August 1998 till February 1999, "D" took care of him single handedly. Her mother in-law was working being the main breadwinner of the family. Her sisters-in-law were attending college. "D" had to constantly sponge his raging fever, give him sponge bath and sometimes spoon fed him. He had constant diarrhoea and his clothes needed to be washed daily. Due to immense pain, he was moody and got irritated easily, She got all the scolding. She kept awake for nearly three months before his death. None of his relatives visited him. His stepbrothers and sisters did help out occasionally by contributing money for his medicine but according her, SASO 's doctor and health worker were the most helpful. They came visiting many times, provided free medicines and counselled her. Her knowledge about HIV and AIDS were gained mainly while her husband was suffering from it. She regrets not being aware of HIV/AIDS before her marriage. This attributes to her ignorance about life and lack of formal education, which gave her few opportunities to explore the outside world. She felts victimised by the whole tragedy and wished to rebuild her life, but she is not so confident as her husband died of AIDS is and she may die too.

Family Attitudes

"D" was lucky to have got married into a kind-hearted family and was being taken care off by them even after her husband's death. The family felt it is not her fault that she became a widow at such an early age. According to her elder-brother -in-law , She is free to remarry if she wishes, but he worries about how her new husband family will treat her. Even if her new husband accepts her, the family is likely to reject her as she is suspected of being HIV positive. He said that he would take care of her son. Incidentally her son is free from HIV infection and is a healthy active boy. But she is HIV positive. Family member treats her as normal. They could and even ate the food she cooked. But some neighbours were mean and gossiped if she went out well dressed for work.

The family considered widows of IDUs as victims of circumstances and felt that IDUs should not marry knowing that their life span is short. But the society put pressure on their son to elope as per Manipuri custom , But after the elopement if a wedding is not held, the girl's family felt that they have "lost of face" hence they force their daughters to marry even after knowing that the boy is a drug addict. In the case of "D" the boy 's family informed that their son is an addict but her parents went ahead with the wedding. Actually the girl's family was not aware of the real danger. Awareness about HIV/AIDS was zero

The families of IDU only tolerated them as they have suffered immensely. They were fed up and were quite relieved that their son died early. This may sound mean but to a family which had supported an addict for more than 7 to 8 years knows what an emotional and mental stress it has been to live and bear them. He was unemployed and hence a pest and a parasite .They tried helping him establish a business many times but he had no inclination and failed, relapsed into his drug habit which annoyed the family members.

However they felt sad at his demise because he was remorseful on his deathbed. His last words were "Take care of my son and be kind to my wife. I had made a mistake in my life, Don't let my son repeat my mistake. Please forgive me". His mother repeated this to the principal investigator with tears in her eyes.

RESEARCH FINDINGS.

Social problems:

Most of the widows interviewed in Imphal as well as in Churachandpur were from the lower or middle-income categories. They were dependent on daily wage. Economically, Manipur is a very poor state; the main source of income for most people is subsistence paddy agriculture. The majority of the population in the hilly terrain lived below the poverty line. The divide between the rich and the poor is very visible in Manipur .Widows of rich families were discourage from joining the "widows self help group" initiated by the NGOs in Imphal. Hence, health workers find it difficult to approach these rich widows, as they are socially isolated from the poor, which are easily accessible. They' are not allowed to go out of their home to attend widows meetings by their in-laws. They have several psychological problems but due to the restriction imposed were unable to share with other widows. Financially they are well off and are able to manage to meet their own requirement from parents or in-laws so they are comfortable in life. There are instances where these young pretty widows were assimilated into the family fold by becoming the concubine of their elder brother-in- law. Their wives and the other family members accepted such situations. Polygamy, since ancient times, was a practice followed by rich Manipuris. The female population accepts it as a norm and made no protest about such issues. This happened to only four respondents and others were hearsay from other widows.

There were five widows age 22 to 25 years that opted for remarriage, to start a new life. But the men who married them were either ex drug abusers or middle-aged men who took them as another wife. Educated young men are aware of the danger of marrying a widow of an IDUs The subjects of this research .About 80% were still single and are likely to remain single all their lives. Though, many are young they feel and don't want to marry again.

These widows are socially isolated because of their husband 's high-risk behaviours. However high the awareness level, IDUs (injecting drug users) are still taken as "parasites and useless human "being in Manipur. So wives whose husbands have injecting habits and abusing drug background are forced to face the brunt of social discrimination and rejection. The rejection is complete when the husband died of AIDS. This further leads to lack of communication within the family members. Such is the discrimination that IDUs (injecting drug users)' wives are the only care providers during their husband's illness. Even the mother and sisters of the ailing patients refuses to attends to his needs because he was dying from AIDS. Wives being wives have no choice but to take care of the needs of their husband. Many husbands (age 28yRs to 37yRs) died a remorseful death, it's was very painful for them to leave behind their young children who are between the age of one to five years. Seeing their innocent's children, they die with tears in their eyes. Some even begs for forgiveness and asked their parents and elder brothers to take care of the small children.

Social Problems:

❖ Mobility of widows was restricted because they are young girls. They were not allowed free movement and were asked to do all the housework.

❖ Parent's -in-laws and social customs imposed restriction on how widows should dress. For complete one-year widows of meitei Hindu faith has a custom of wearing an off white and white cloth as a sign of mourning. After that they feel awkward to be dressed in colourful clothes again.

❖ Having a status of being wives of IDU, society tends to look down upon them. This further lowers their self-esteemed.

❖ Majority of the widows said in-laws blamed them for the untimely death of their husbands. Two widows specifically were asked to leave the house after her husband died because she was an unlucky mascot for the family.

❖ As many were presumed to be HIV positive there are instances of property rights denied to at least 10 widows whose husband had the rights of inheritance being the eldest son of the house.

❖ Some five young widows were stopped from remarrying because of their small children.

❖ Customary tribal laws do denied them their children in case of remarriage. Divorcee and widows were allowed to remarry before HIV epidemic came to the scene but the custody of the children goes to the husband or the family.

❖ They were allowed to live in the house of their in-laws as a charity dole by giving them small dingy room.(most of the IDU lived in their parents ' home.)

❖ Family members were suspicious of any male visitors, even if they were health workers from NGOs, their movement were closely monitored

❖ Family members ,brothers and sisters of husband are not sympathetic to them

❖ Males target them as easy sex object. There are cases of young widows being sexually harassed.

❖ Family sizes in Manipur are normally big, some have15 members living in a joint family setting in one compound. The smallest family size is four members.

❖ Attending a Self-help group meeting improved their social statuses they gain more self-confidence. It provides them a place to relief emotional stress. This facility cannot be avail of by widows that has influential father in laws or rich parents because of prestige issue.

❖ Relatives and neighbours brand all widows of IDUs as HIV positives.

❖ Sick widows of IDU are not treated well in local district hospital, They have no support from doctors and nurses, even if they are admitted in hospital, treatment melted out to them amount to violation of human rights, it is almost stigmatisation from the medical community. Almost no support from husband's family. They are neglected and return to their parent's home to die.

❖ Older widows of > 30 age group felt that they are respected by society but the young widows and sex partners of IDUs were looked upon as loose character, since they have many sexual partners. This is because some young widows do indulged in sexual activities with other men.

❖ While the husband was ill, neighbours shunned them; even the children were not allowed to play with the other children. The husband's families did not provide any financial or emotional support. The whole community treated the families of IDU as outcastes.

❖ The death bodies of an AIDS pa-

tients was feared in 1993, a widow, who is in her late 30s, related an incident, which happens, when her husband passed away due to complication related to AIDS. The whole family swooped down and removes the body as quickly as possible and burned all his bedclothes, even the plates and utensils he used for eating were thrown away. The whole house was fumigated and nobody was crying for him. Every body emitted a sigh of relief. The family members ignored the widow's sentiment totally.

❖ About 50 widows express their feelings of embarrassment about the way their husband died, at 25 or 30 years of AIDS. Everybody presumed that they too will die of AIDS and friends started avoiding them

❖ Widows of IDU were lonely people, as they practically have no social life. They were busy trying to make ends meet and have no time for socialising.

❖ There are many scared and hidden widows who did not come out for fear of social ostracisation.

❖ Because of societal pressure they hide the truth that they are widows of IDU especially when they go looking for employment in the homes of rich people. They pretend as if their husbands are still alive.

Economic problems:

♦ Stark Poverty stares at their faces Almost 80 or 16 % of the husbands of these respondents were self-employed while alive. But majority of them was unemployed due to their injecting drug habits, so financially, the family were poor before and the treatment expenses during IDUs illness exhausted what little available financial resources .They leave their family with big debts and surviving everyday becomes difficult Making a living / inability to feed the family is the biggest economic problem faced by these women

♦ The illness and death of the AIDS patients plus the funeral and other ceremonial expenses left them in debts and the widows felt mentally very burdened. They out of exhaustion fell ill. They felt drowned in a depth of loneliness and helplessness with no one to take care of them. It is only the small children who provide solace to them.

♦ Lack of assets and no properties rendered then totally helpless when it comes to fighting for their property rights. Many have no property left behind by their late husbands to initiates income generation. So they have to start anew. They could not and did not avails of government' s schemes and loan, as they had no knowledge, education concerning such facilities.

♦ Social stigmatisation is an obstacle in their paths. The poor economic condition of the widows discriminates her further and she is even afraid to come out of her house to avail of the resources provided by the NGOs or the local hospital due to social stigma.'

♦ Widows of Manipur carry the sole burden of being the sole bread earners of the household. A majorities of these widows (80%) were self-reliant. Many are self employed, about 90% widows engaged themselves as vegetables sellers, as street vendors, as daily wage earners, cleaners in rice mills, as washer woman. But the older widows were economically better off, they have small business, such as a small hotel, pan dukan, tailoring, pickle making, embroidery, community revolving credits systems group (where they contribute certain sum of money and each one get the total sum by rotation and it goes on until all have got their share), 5% are employed as nurse, school teacher, clerk. But more than 50% of the younger group are unemployed and are still dependants on parents, in-laws and on relatives. Some cohabit with single or married men for economic reason

♦ Being deprived of "what is theirs" Many of IDUs in the age group of 23yrs to 30yrs were unemployed. Only five were employed in government job. Out of the 250 odd widows, only few were given assets or share of the rice field after their deaths. Under the "die in harness schemes, only two widows of IDU were given a job after their husband's deaths. Some widows are deprived of this facility as the in-laws feels that the younger brother deserves the job better because the widows being already infected is likely to die sooner than expected. Government jobs are lucrative in Manipur, as there are no industries. Unemployment among educated youth is also rampant, (there are more than 10,000 educated youth registered at the employment exchange but only about 100 youths managed to get government jobs which are favoured).Job are scarce in Manipur because of there are no industries). Widows being illiterate are deprived of this opportunity. Moreover widows have very little say in family decision making

♦ Burden of being dependent on husband 's family. 90% of the widows do not go back to their parents ' place, in fact they preferred to stay behind at their husband's home and are either taken care of jointly by other brothers of the deceased man or by the in-laws. The mother and children are given one room and the mother is asked to work as maid or as vegetable sellers to meet their meagre income. The attitudes of the other sister-in laws and the cousins are sometime mean and bad, especially to the children. To be dependent for housing also irked the widows.

♦ There is no welfare Programme formulated for children's by NGOs as well as by state run AIDS society. All the widows said their children are the main reasons for their living and their only hope. They wanted to provide the best for them but were unable to do so. They had little money for food, clothing, medical treatment, children's school fees etc. Their average income per month was RS 1000 for 45 %, 800 for 35 % and for the rest 30 % it was 500 rupees a month. This meagre amount for a small family of four is insufficient. Besides the government of Manipur has some widows schemes in social welfare departments But nothing concrete had been done for them and their children.

♦ Children's education was the top priority for these widows. Respondents 's main care and concerned was to educate their children. In Churachandpur town, there were some charity schools run by the Paite community, that provides free schooling to bright children, Some widows managed to sent one child but they wanted to educate all their other children (Sometime five in number, families size are large in Manipuri family, average kids is 4 to 5) 80% of all the respondents are having children ranging from one to five in numbers)

♦ Widows usually land themselves in debts.. In order to meet the demand of

their growing kids, widow borrowed money even if they could not afford, sometime landing them in deeper debts. In cases like these, the mothers hire out their 8-yr. old to 10 years old children to work as helpers or as maidservant in rich people's house. In this way, they managed to get a monthly income of Rs 600 or so, which they saved for their future. This is one way of ensuring and securing her children's future. These are desperate times and situation but they eventually want proper education for their children.

♦ Infected Widows (about % 5) who are symptomatic were weaker physically. They found it extremely difficult to earn a decent living due to their poor health. They were unable to engage in sustainable, guaranteed employment. Moreover people did not want to employ them, as it was a waste of money and time for them to invest on these unhealthy widows. Besides these widows fear others knowing about their HIV status hence they are afraid to go and look for work.

♦ Being illiterates hampered the chances of widows to earn a decent living. There were no avenues for any government job or any other job because most of then were illiterates and very poor (jobs have to be literally bought in Manipur through bribes. This is a phenomena common to Manipur)

♦ Lack of finances prevent them from going to court cases for legal matters and also for securing their property rights, husband's pension, child custody etc.

♦ Many poor widow' felt that they were better off now financially then while the IDUs husband was alive, because his demand for drug money was too much to bear. Sometime the man earns and spent all his earning on drugs; sometimes he even steals money kept aside for food .Now she is more free to earn by working hard and can spent for the children too.

♦ Economic need lead them to moral degradation. Due to extreme economic problems, 20 of them have resorted to activities or lifestyles such as commercial sex or cohabiting with brother -in-laws in exchange for security and financial support to their children.

Psychological aspects:

The research clients are from Imphal and Churachandpur, that the majority of widows are Hindus. But the widow's of Churachandpur are from Christian

Hindus society practices widows discrimination, because such practices as forcing the young widows to wear the off-white or beige "phanek" and a white duppatas, wear an ash coloured vermilion mark, (a sign of being a vishnavaites Hindu) as a mourning outfit for one year. This attire clearly marked them out as widows and being very young they are reluctant to attire themselves for one long year but the husband's family insist they wear this mourning outfit. So discrimination of widows in general was not a rampant practice as compared to the other Hindu states in India, but for some orthodox Hindus some norms and prevailing customs regarding widows are still practice. They are debarred from attending such auspicious function. Majority of the widows interviewed feels more looked down upon than the other widows, as they were wives of IDUs (injecting drug users). So social discrimination and being widowed at such a young age creates many psychological problems.

Psychological/ emotional problem faces daily by these widows are as follows are as follows:

The psychological issues faced by most people with HIV infection or any disease associated with the infected person is revolved around uncertainly and adjustment they have to make in their life (In this case in life after their husbands died of AIDS). The fear of being HIV infected by their husband uncertainty emerges with regards to hope and expectation for their future. In this regards small children are involved, as small as one to five years old. These women focus their target mainly in finding a job, earning a minimal livelihood, in order not to starve and in keeping their family intact, without the presence of the father. They played a dual role of being bread earners as well as security providers with uncertainty in regards to their quality and length of life, as most are already with the HIV virus. Life is unpredictable for them in terms of long term output. To make adjustment with their lives even if they fear the uncertain future. They have to undergo a lot of tensions which cause other certain Psycho-social issues to assumes more or less prominence and intensity from time to time. Most of their fears and low self-esteemed arises from experiences of love ones (Husbands), friends, or relatives who have been ill and died of AIDS or of TB. So they do faced a lots of emotional upheaval and psychosocial problems such as the follows:

- Feeling Of Inadequacy
- Deep Depression Due To Loss Of Head Of The Family
- Feeling Of Being Abandoned,
- Feel Worthless
- Insecurity
- Loneliness Because Of Alienation (Imagined Or Real) By Society
- Fear Of Dying Young and alone
- Greatest Fear Is Fear For The Children 'S Future
- Besets With Lots Of Regrets In Life such as loss of ambitions, their physical attractiveness ,sexual relationship, status in the community
- Feeling Vulnerable
- Crying spell for no reasons
- Anxiety
- Illness due to anxiety
- Insomnia
- Anxiety about HIV infection
- Totally devoid of feelings/emptiness
- Great anger at their current situation
- Majority of them feels victimised, especially, so among slightly educated widows of Imphal. While in Churachandpur they say don't perceived themselves as victim of circumstances, but as destined by god to suffer,
- Majority feels as if they are living on edge of precipice, ready to fall any minute
- They are disturbed as they feel they have led an unfulfilled life,
- Majority of them said they would have commit suicide if they were no children involved. (studies shows that no young widows have committed suicide so far , some of them who have followed their husband to their graves soon after died of AIDS or other opportunistic disease themselves)
- The emotional bonding between the widowed mother and her children be-

me stronger after the death of the fa-
r, more so because they all, suffered
gether.

- Widows take out their frustration
their innocent's children by beating
em and blaming them but they always
els guilty later.
- They are extra sensitive to any form
criticisms.
- They all suffer from low self es-
emed/inferiority complex
- Become less sociable after becom-
g a widows
- Emotionally still very burden
- The burden of silence
- Older widows feel insulted when
xually harassed by men, on the other
and younger widows in their early 20s
elcome sexual pass and go in for sexual
elationship with many men who ap-
roached them. This they described as
eir rights as they biological needs have
be met somehow, according to them
idows who are HIV positive for no fault
f have a right to lead a normal life.
- Effectiveness of occupational
herapy will provides some relief but its
eyond their reach
- Society's perception of these wid-
ws as HIV positive just because their
usband was, put in a lot of emotional
train on them, they feels like an out-
aste as some puts it.
- Lacked of education and unskilled,
alents barred them from earning a decent
iving. This causes a lot of stress on their
ealth, further accelerating their death.
- Some widows are already show-
ng symptomatic sign of being HIV, few
are terminally ill, so medical problem has
an adverse effects on their mind, making
them mentally unstable.

The coping pattern of widows in terms of economic, social and psychological pattern was explored among these women. They were divided into different groups according to their age or according to the self-help group they belongs. To what extend have they been able to cope were explored and the finding were startling.

Coping Mechanism:

The main reasons given by majority of the widows was

1. Their survival instincts are very strong, because they have small growing children. They feel that they have to live for their children's sake. So they make themselves strong emotionally.

2. The levels of motivation to improve their lifestyle among widows who are member of the "self-help Group" are high. Since fate has played a cruel trick on them. They feel victimised by their circumstances but at the same time they are determined to lead a better life for their children and themselves. It was as if they are rejuvenates after years of suffering and wants to have a better life.

3. They are not selfish but courageous because they want to help the younger unmarried girls from marrying IDUs (injecting drug users) who cheats or tricks girls into marrying them by pretending to be non-drug abusers. The noble idea of helping young, unmarried girls from a plight similar to theirs, keep them motivated and strong and this courage gives them the power and energy to cope with their daily living.

4. Role "health worker". The daily visit from a lady health worker while she was in deep depression helps her overcome her depression.

5. They are also able to cope due to their "strong faiths" in god. The widows in Churachandpur are Christian, and who has strong beliefs in the power of the supreme god. The churches have some women societies with widow's Programme that provides economic and spiritual support. The widows of the Hindu faith too put a lot of emphasis on god's love and god guidance in their daily life. It is their strong faith and beliefs in god that make life bearable everyday.

6. They faced lots of discrimination and opposition in their lives. This makes them more determine to fight out their battles in life and be acceptable in the society. This keep them going and strong enough to tackle any problem in life

7. Peer support from other widows in the "self help group" helps them cope better .It provides a platform for them to share experiences and lightens their pain. Quote" one widow say that "HOPE", a self help group for widows gave her courage to empower herself for a better future.

8. "Positive attitudes" Keeping them extremely busy in works makes them forget their sorrows.

9. Some widows have lots of "support from in-laws and families", which allows them to go out and earn their living by taking care of their small kids. Quote from one working widow " my mother in- law take cares of the house and my children and I am free to go to office and attend widows meeting whenever I wish too. It's only four of us in the house, my two children, and my mother in law and me.

10. "Hope of a remarriage "makes them feel alive, specially for the non positive young widows. Some parents and in-laws are so supportive that they arrange remarriage for their widow's daughter, to some old bachelor or friends of the family.

11. Out of sheer "grit and determination"

12. "NGOs' " motivated them and gave them monetary loans to restart their lives.

The formation of self-help group for these widows

A self-help group for widows was formed in two districts of Manipur in 1998, with the following aims and objectives

To provide specific knowledge among the members about the role and responsibilities in fighting HIV/AIDS

To provide a platform where they can exchange and share personal experience and general information and skills to cope up with the prevailing situation or any situation in their lives.

To empower themselves in having easy access to proper treatment, regular medical care and home care when they fall sick

The benefits of self help group according to the widows response are as follows:

This self-help support group of widows does not see AIDS as an issue which can be separated from the other issues it tackles on a daily basis.

The meetings of the widows have in fact enhanced and provided practical values and also enhances their self-confidence and ability to take control of their lives individually and collectively.

Such kind of meetings is helpful to the widows because they get advice on health care from health professional.

The meeting also serve as a focal point for their interaction and exchange of family and personal problems which they are unable to share with others otherwise.

To some members the love and acceptance they receive from the other group members motivate them to begin life with dignity.

To some, the self- help group fills the emptiness from which they suffered from their husband's expiry.

It's a relief to them to know that there are others like themselves

They feel more empowered and stronger now, so are able to talk about their HIV status much more openly. They now openly disclose their status at the meeting.

They accept reality and develop a positive attitude towards life. They are able to face the consequences of being HIV positive and what effects it will have on their life.

The bonding between these young widows are very strong and this gives them improved self esteem .So they feel that discrimination and stigmatisation they face has become less because they are stronger emotionally.

They act, think, cry and laugh, together providing support and comfort to each other.

Some members are willing to become AIDS educator in their locality, to spread the message of AIDS to the community at large who are still fearful of HIV/ AIDS.

What the NGOs are doing for them?

ISD (Institute for Social Disease) had been involved with HIV symptomatic IDUs (injecting drug users) for a very long time now, soon these IDUs (injecting drug users) started dying. From July 1993 to 1997, many married IDUs (injecting drug users) about 38 ,died leaving behind their wives (31) and sexual partners' (6). They were involved with promotion of safer sexual practices among the 31 widows of the IDUs (injecting drug users) and also among the sexual partners of the IDUs (injecting drug users). They realised that these widows are either infected too and face lots of discrimination because of the manner of their husband 's demise.

Besides lot of social and economic problems faced by the widows, the number of widows of IDUs (injecting drug users) also increases unless something is done about it, these widows out of extreme poverty resort to commercial sex, putting themselves and others at risk of HIV infection. ISD after a lot of thought decided to start widows Programme in Ids itself. The main aim was to reduce risk of HIV infection and attainment of economic self-reliance among the widows.

IDS on 8th march 1997, in a meeting held at the drop- in- centre decided to established a self-help group for widows .as the need was felt urgently. They named it "HOPE" horizon of prosperity & education. The group aim to share common problems and to help one another. Some rules and regulation was made which was to be followed by the group members themselves. The rules are as follows:

1. The members will meet once a month to share experience and learn from each other.
2. To work out things together with unity by helping and encouraging each other.
3. To increase the number of members as the need arises
4. Each member to raise group fund will contribute small amount of money.
5. If a member of the group to remarry, she must inform the group two month ahead of time and has to resign her membership.

Some actives taken up by ISD are as follows:

* ISD had established small scale income generating units for these widows
* Remarriage for young widows who are not HIV positive
* Provides psycho-emotional counselling
* Provides training on safe and safer sexual practices.
* Educational Programme once in three months to improve knowledge on various areas
* health checks up twice a year for the widows and her children, medicines are provided free, doctors are from other NGOs or from hospital
* Recreational activities by organising a one-day picnic every six months.
* Soft loan on personal basis given to the very needy
* A three day workshop on how to overcome the health/economic/psychological problems of the widows was held on 29th august to 31st July was carried out for 34 widows.

SASO (Social Awareness Service Organisation) also in line with the same idea had scheme started a widows Programme for widows of IDUs (injecting drug users) whom they had taken care before their death. They have only eight widows as members and a one-lady counsellor with them. The reason why they had a small Programme for widows is that they lack funds. They named this group as "CARE". SASO according to their own survey, they have identified around 80 widows in their work area, but has been unable to initiated work of rehabilitation, for all of them. They have taken in only 8 widows, who were wives of the death IDUs (injecting drug users), that SASO took care of while they were dying. They were obliged to these young widows because by then they have became too dependent and their emotional /psychological well being after the demise of their husband was at its lowest. SASO therefore chose eight (8), young widows, rehabilitates them and financially by giving a salary of 750 to 800 rupees. They also provide training for them on block printing, embroidery work, tailoring and make them attend workshop on safe sexual health practices, But they are unable to provide loans for these young widows. NGOs have to play multiple roles while dealing with IDUs (injecting drug users) and their sexual partners.

CSD (Centre for Social Development) because of their concerned for

oung widows who are helpless in the ociety. CSD started a self-help group alled "hingminnaba" which literally eans to survive together in April 1997. SD has a membership of 36 widows nging from 18 year old to 45 years old idows. But all are not widows of IDUs njecting drug users). They have widws' Programme in general. The main im is to empower these women by proiding some financial help so that can e-established them.

The first step they took in this direcion was to give a long-term loan of RS 000 to 18 very needy widows with a ery low interest payback rate of 1% nly and to start a thrift credit system mong the rest of the widows. The ittle profit they earned was pooled nto their "self help group" bank acount and when it reached RS 1000 or more, some skilled and talented widows were given the money and asked o increase the amount. Some knit a sweater and sell it for a profit. Some weave a "phanek", some knit a socks and baby cap and do all kind of activities, the profits are then pooled together again and given as loan to a needy widows. In this way, the money get circulated and generated among themselves only making them self-reliance. In this way CSD hope to make the group self reliant and independent. Most of the widows of CSD are running small business of silver smiting, once they become experts they will switch over goldsmith work.

CSD has so far provided training for widows on

a. On how to get organised in their life , their business

b. They were provided training on accountancy. how to utilise their money properly

c. Were given exposure to other women self help group in order to learn and share experiences, so they were given TA/DA to attend workshop held in Imphal.

d. For recreation they were sent for picnic, organised by CSD and vehicles were provided for them

e. Counselling and condom are provided to these women

f. Place. A room for their Sunday weekly meet is provided by CSD.

Some rehabilitation Recommendations for widows

➢ Property rights of these widows should be restored and not denied to them or their children

➢ Social/economic Support in terms providing small time loan with no interest for maintenance of her self and her children

➢ Mobility restriction by society and parents in-laws should be to be removed, so that they can go out and earn their own living however meagre

➢ Feasible trade for economic rehabilitation of illiterate widows such as food processing scheme provided by the women development programme under the Industry Department should be made available and accessible, with the help of NGOs or Go for all widows of IDU.

➢ All existing NGOs and GOs should provide facility for vocational training such as embroider work, block printing, pickle making, pottery for widows especially unskilled one. This can be done in collaboration with the social welfare department, small-scale industry department, which in turn will provide sustainable job for them.

➢ These skills can be acquired by other women in Manipur therefore it is the duty of the government agency or local NGOs to find an outlet or help in setting up marketing section for sale of the widows ' products.

➢ The most feasible work for majority of the widows will be starting a small hotel /teas shop /pan shop/fast food joint like Chinese/ momo stall/vegetable vendor, where all the basic ingredients are easily available within the locality where they reside.

➢ Discrimination And Stigmatisation to these helpless women should stop if society is to move forward and progress

➢ Government hospitals and NGOs should provides regular and free health check up for them

➢ Increasing the awareness level by providing educational knowledge on how to lead a positive life even if they are HIV positive.

➢ To motivate the widows to be become self supportive financially, so they do not become over dependence on NGOs and GO for their future sustainability.

➢ Local leaders and important members of the community and NGOs should take more active participation in the issues regarding HIV/AIDS if the youths are to be saved. Full time involvement s is needed now.

➢ Majorities of widows are very poor and are unable to meet their medical expenses. All Donor Agency, World Bank, WHO should provide funds to local NGOs to distribute necessary medicines for widow's living with HIV and AIDS.

➢ HIV test before marriage should be encourage for all youths especially for the ex IDUs or current IDUs. But post & pre test counselling should be provided.

➢ All Manipur layers association of women layers should network with other agencies for protection of human rights and be human resource person for imparting legal awareness. They can also try and develop legal policy for women living with HIV/AIDS

➢ NGOs and GO should develop capacity building for the sake of empowered Widows and spouses of IDU by providing training programme on preventive and intervention measures, improving skills on negotiating and communication skill, to lessen exploitation. (It was found that majority of widows lack communication and condom negotiating skill with their sexual partners) especially in Churachandpur districts

➢ There is an urgent need to raise awareness and improve knowledge on issues related to HIV/AIDS. Correct and proper information on HIV should be imparted to young unmarried girls in all the localities in Manipur, whether urban or rural.

➢ HIV and Sex education should be imparted in all school, govt & private in rural, as well as in urban areas

➢ Women related policy concerning widows should be taken up by MACS

➢ AIDS is not just a medical problem. It has become an socio-economic development issue that affects everybody in the society and should be considered as such.

➢ Not much hype about HIV/AIDS related deaths now-a days.

➢ There should be better co-ordination between NGOs, referral centres, service cell, and counselling centre and rehabilitation centres in Manipur

➢ There should be better co-ordination between NGOs, referral centres, service cell, and counselling centre and re-

habilitation centres in Manipur

➢ MNP+ (Manipur network of positive people) should have members from all over the states , There should be close linkages of MNP+ with MACS an GO (Manipur state AIDS control society) so as to influence policy makers.

Strategies for Rehabilitation. The Need of These Widows:

In order to rehabilitate these widows certain recommendation are already found out but how to formulate strategies for rehabilitation can be as follows:

a. Legal policy for women to be formulated .The legal aspect of HIV/AIDS with regards to these widows, are

- Right to live lead a normal life
- Right to marriage
- Right to property
- Right to give birth
- Right to privacy

b. For social acceptance of widows of IDU, Community sensitisation programme is another area to be given emphasis

c. Small amount of hard cash in term of loan with no interest from social welfare scheme or from any other government agency should be made accessible to these widows.

Crèche or Child cares centres for the children of working widows or when the mother falls sick. This facility should be provided either by NGOs, GO or even local housewives for a few hours a day. Orphanages are not an answer as they will become institutionalised and the children affected by HIV/AIDS will further become isolated and alienated from the society. Instead recreational centres for them and their children are more important to keep them happy

d. There should be active networking with all SHGs (Self-help groups) from all part of Manipur in the form of combined meeting, picnic at least once a month. With the help of NGOs. Formation of other SHGs should be encouraged in town like churacahndpur, Ukhruls and other districts with the help of HOPE, ICHE etc.

e. providing them with skill building training programme

f. educational knowledge on health care and motivation for positive living more emotional support

g. New vaccine and AZT should be accessible to pregnant widows who are already infected by HIV. Medicine are unaffordable for majority , at least free medical treatment at the terminal stage should be provided at home

h. Hospitalisation is not preferred as they feel lonely, discriminated by nurses and other hospital staffs. Therefore the wishes of the patients should be attended to, most express a desire die at home and they should be allowed to die in peace

i. Psychological /emotional support in the form of counselling should be able to provides close emotional bonding within the several "self help" groups.

j. Practising safe sex for widows who are infected with HIV should be encouraged. Family planning is also one areas to be explored especially if the widow had already given birth

k. NGOs and GO should provide more counselling for young girls school & college going and young widows who goes in for casual sex

l. No more denial and complacency about HIV epidemic in Manipur, acceptance by society should be more open. Community support for the widows of Manipur is important.

m. Hospitals and government run clinics are unfriendly and judgmental. NGOs should provide youth friendly hospitals and clinic. This will reduce the incidence and prevalence of HIV and STD can be managed better.

n. Foreign funding agencies like ActionAid and others should provide finance for capacity building to NGOs for providing vocational training's, to help widows for income generation Programme.

o. Arranged matches for widow marriage should be fixed among HIV positive people.

p. Widows need love and affection from others. They need to be respected and lived in dignity. Mental relaxation is important also to die in Peace. The ailing widows require a kind of remand home or a hospice, a mid- way home for them, to be attended by loving people. There is one home rehabilitation centre (Sneh bhawan)who take in very sick women who are dying of AIDS in Imphal and one hospice in Churachandpur town.

q. Combined NGOs, GOs and MNP+ to form a forum for tackling laws, ethics and human rights issues, which should be effective with the combined strength.

r. HIV/AIDS should be an important and necessary issue to be lobbied during the state election to make it a state mandate. Otherwise the politician ignores it, as not important enough for development programme.

s. Young women should be empowered more and more, so there will be fewer widows.

t. There should be women friendly HIV testing centre. Conservative women feared to approached testing centre due to social stigmatisation.

Q Parents and public should raised the issues of providing sexual health education in schools and colleges for their children

u. Existing alternative medical resources should be utilised, traditional healers like "siampus, maiba and maibis' s" services should be sought.

How the society perceived these widows

Majorities perceived widows of IDU as victims of circumstances

❒ Dumb, illiterate, desperate and ignorant women. Unaware about HIV/ AIDS epidemic in Manipur and the world. These were an indication that awareness level had not permeated all section of the people in Manipur.

❒ Widows perceived themselves as being cheated and dupe by IDUs.

❒ Some public opinion was that these widows got what they asked for by marrying a drug addicts, they feels that these young girls marry at an early age without thinking and without completing their studies, they are promiscuous in nature and spoilt their future themselves.

❒ About 50% of widows are from poor family so they don't mind marrying an IDUs from a high status family. By marrying a rich man son they presumed they would have a better life without realising the consequences. After the death of their IDUs' husband they get assimilated into the joint family system and lead nondescript lives looking after their children.

❒ Families and parents-in-laws considered them as an additional burden, especially if they have no talents and skill.

❒ Some police official, doctors and ealth workers of NGOs are of the opin-ons that widows are "Part time kasubis" d-hoc prostitute, posed as CSWs, nainly part time and operate out of their lace of resident. The names given to hem "wheels", as they are mobile. This poilt the reputation of the other widows vho are struggling to make ends meet.

❒ Young men and adolescent boys egards these widows as easy sexual ob-ects so do the IDUs who utilises the exual services of these widows.

❒ General publics see them as " car-ier of AIDS" and do not like their good sons to marry or have any sexual contact with these widows.

❒ Society sees the sexual partners and widows of IDUs are as future landmine of HIV/AIDS explosions.

❒ Community regards IDUs and their wives as outcaste and said that AIDS came into society, and permeates into the community because of lack of morality.

❒ A college going girl feels that if an IDUs is HIV positive, he should not get married at all because it is not humanly possible for a married couple to practice safe sex and moreover condom are expensive. If he wish to marry he should marry another HIV positive girl, why spoilt another persons life.

❒ Many educated parents feel that horoscope matching is not important but pre marital HIV test is more important. Majority of the valley Manipuris are Hindus, so after they eloped the parents matched the children's horoscope after they agree for the marriage.

❒ Majority sees the widows as lacking in motivation to improve their life for themselves

❒ Stigmatisation was so pervasive in the early years in 1993-94, that bad memories linger on for some older widows and they feel defeated in life.

❒ One Panchayat leader said the stigmatisation is lesser in his village now and widows are treated well.

❒ According to one lawyer, widows are a deprived lots!, They are deprived of everything, of a fulfilling life, of happiness, of love, of property etc.

❒ Social workers feel that they will benefits if they are united and form a registered society or a NGOs. Then they will be more effective within the society they lived in.

❒ As good care providers, widows should be trained in proper health care. So their services ca be utilised by hospitals, clinic and hospice.

❒ Many people felt that widows' empowerment will reduce HIV infection, also their respectability in the male dominated society will increase, giving them more negotiating power

❒ Good resource persons. Widows given a chance will make a better teacher for promoting AIDS awareness programme also a good social worker, a more sensitive counsellor if they are employed in this field.

❒ As destroyers of marriage. In-laws and other women blamed these widows because their husbands take them as concubine. Widows' remarriage are being practices but many people in the society were of the opinion that, its better to remain single because they are HIV positives and can spread the virus further.

❒ Nurses and private doctors in Manipur treats IDUs, their sexual partners as a potential source of income. The richer the patients the better for them Treatments and attitudes of doctors and nurses depend on the income of the people. If a rich man son suffers from AIDS, his status is hidden from the others and doctors treat him well, but for a poor man he is asked to leave the hospital on some pretext or the other.

❒ NGOs feels that there is no need for hype about HIV/AIDS related deaths now-a days.

❒ Counselling Centre and Rehabilitation Centres in Manipur sees them as clients.

❒ MNP+ (Manipur network of positive people) sees them as numbers to influence policy makers and as a motive for mobilisation a movement.

❒ Outside agencies and research institute sees them as potential material for research topic.

❒ Militants see them as useless human beings that need to be removed.

❒ Church leaders as burden to be borne by the church.

Summary

HIV/AIDS is here to stay in Manipur unless some drastic measures are taken for the general population of Manipur. HIV was amidst IDU only in the mid 80s to early 90s. But now in 1998-99-2000, the scenario had changed, IDU are spreading the virus to their wives, sexual partners, their children and the whole society is caught up in vicious circle with no end. Manipur which housed Mangoloid race with long life span because of the clean environment are reporting now of early deaths among younger generation. The death statistic and the cemetery tombstone are proof that shows maximum deaths occurring between young male in the age group of 16 to 40 years. The older men lament over the deaths of their young sons. The main culprit is AIDS and insurgency.

The social culture in Manipuris very much different from the rest of India. It is basically a tribal society and customary beliefs and practices govern their way of life till today. There is no system as an arranged marriage in Manipur, so most youngsters find their own life partners. The way and means of finding a life partner is very interesting indeed. Most marry out of love and elopement is the most common form of marriages. There are instances when the boy kidnaps a girl if he find her pretty and the girl has to just accept him as her husband. She may not know the boy personally before but she will marry him and can live a happy life.

So also in the case of these young widows, they had a love marriage, none of the marriages was arranged by their parents, nobody had church wedding and only the few Muslim had a proper Nikka ceremony.

Young women in Manipur do not hesitate to marry IDUs. In fact, many young girls are getting married at an early age; (the latest trend in the 90s shows girls eloping at about 16 yr. to 17 years. About 50% of IDUs are very smart and possessed a high IQ, they are also handsome, like to dressed themselves in the latest western outfits and are glib talkers. Some IDU are already infected with the HIV virus but they still manage to win over these young girls very easily, who may or may not be ignorant about HIV/AIDS. Some girls claimed that they are not aware of their husband's injecting neither habits nor their HIV status. This is the case because they without knowing each other properly get married, as they are in love. These girls were not infected with HIV at the time of their marriage, but later got infected by their husbands. After marriage, he died soon after, leaving her a widow with one or two children to care for.

In Manipur there is no taboo on widows remarriage, so these widows young who are without children do remarry sometimes. But the second husbands they marry are either IDUs or husband's friends who took pity on them. Some ex-IDUs are eligible young men for these widows or if they happen to marry young men who are not HIV positive is because the boys are not aware of their HIV status. In this way, the virus spread from one infected widow to another uninfected boy. As awareness spread, widows of IDUs are considered as unfit wife material. The customary laws of the Manipuris do not allow these young widows to take along their children to their new home. The husband family has the full and sole custody of the children. In this way these young widows restart a new family and a home for themselves if they manage to marry. But majorities of the widows have no future plan of remarrying.

Sometime, these women are asked to leave their in- laws' place because of the stigma attached with the HIV virus and as social understanding of HIV/AIDS is still not very acceptable. There is still phobia about this epidemic. Sometime they are ostracised by the community they live in. In desperate situation these women become more vulnerable and are exploited thoroughly by different men.

Some of them are young, have just got married, and got infected. They are still very healthy. These women are luckier than the older widows who are already sick and are burdened with one are or two kids are.

These women need socio-economic rehabilitation and a shelter for themselves and their children. Most of all, she needs to be economically independent, but so far nothing has been done about them. Some women, who are thrown out of their homes, find temporary home for a few months in places like Sneh Bhawan in Manipur, Shalom AIDS's hospice in Churachandpur. In Bangalore, they stay in a place like "Freedom Foundation" and "Snehadhan" or "Michael Care Home", in Delhi. But how long can they stay at places like these, they are supposed to stay here only for a short period. In Manipur there is no such facility available for them, so unable to earn and fend for them, they stay at rented house or go back to their parents' home to die in peace.

The social and economic consequences of drug addiction in Manipur are being felt now in the late 90s when we are entering the new millennium. This has been manifested by the fact that Manipur is the only state in India that has the maximum numbers of young widows in the 20.yRs old age group. Since the epidemic started in 1990, the numbers of injecting drug users didn't abate but took on a steady climb and adolescents also joined the bandwagon. Meanwhile the older drug abusers, who were pioneer in drug abusing since the 80s, decided to go in for marriage and had no problem in finding a wife, they chose a wife who is both ignorant as well as innocent about HIV/AIDS.

The very fact that IDUs can find wives shows that the awareness level among young girls is not very high. Most of them claimed that they were not aware of their husband addiction and are not well known to them. This reflects badly on the "openness and freedom" given to children to choose their own life partners, without any screening from parents. The social and economic condition is so poor, the majority of people lived below poverty line and each household has more than four children but the monthly income is not more than Rs 5000. Hence many young girls from poor families opt for an early marriage as an alternative for a better life.

Heroin was a hobby for many rich kids in the 80s and women for a wife are in plenty. Caste system did not exist in Manipur and being a tolerant society; wives are taken from very poor family too. So these rich boys are very much in demand even if they are drug addicts.

Therefore they get married as girls accept them. Some of these girls are aware of HIV/AIDS and should accept the consequences. They do that because many of these widows come from very poor economic background. After the demise of their husband they have no choice but to remain in her husband 's place. A very interesting case study highlights the plight of young women who get married to Injecting drug users.

Example, one young girl got married into family where all the three brothers are heroin addicts. She married the second brother who died of AIDS. Soon after, instead of returning to her parent's home she decided to marry her elder brother -in -law, had a child from him but he too dies soon after, still she refused to go back to her parents after being widowed twice. Finally all three brothers died, the last one died in October 1998 but this young widow is staying living with her son and her in-laws and one sister -in-law. The in-laws also accepts that young widows do remain behind to take care of the small child and many young widows are being looked after by the husband's family. This is a typical case of a high status, well to do family. They will continue to live in their husband's home until they remarry or till she dies. Which can be quite a while evens though she is already infected with HIV. There are many cases like her; they're the victims of circumstances. These young widows are doubly victimised by society; they get discriminated as well as get infected with the HIV virus. But some widows are not blameless; they marry an IDU knowing that he is abusing heroin, so they have to take responsibility for their action. These young widows are HIV positives but they still have many more years of productive life, if only they are allowed to live a life of dignity. They (most of them) can lead a very productive life as majority are still in the asymptomatic stage.

In Imphal, Widows discrimination are more than in Churachandpur because they are Hindus and the customs demands that widows follows certain norms associated with widowhood but for a tribal society who practices Christianity widows are not discriminated at all. There are larger numbers of widows of IDUs, in Imphal than in Churachandpur. This is because Injecting drug abusers in Churachandpur are young and unemployed boys and parents do not force them into marriage. Most of the widows are widows of alcoholic but in Imphal, once a drug addict goes in for a six month rehabilitation Programme, he is considered "cure of the heroin addiction' and the his mother feel its better if he marry. IDU mothers idea's and perception of their IDUs son's welfare is getting a wife for her son as one way of trying to stop him from continuing with abusing drug. Drug addict' s mothers belief that their sons will become free from drug, once they get married. This wrong myths should be dispelled because changing habits and attitudes of an adult IDUs is almost impossible and that drug addiction is a disease which can be cured if only the abusers wished to do so. Many a time an HIV positive IDU did not want to reveal his HIV Status to his parents and to the girl's family, so if he refused to marry, they probed and cajoled the boy to bring in a daughter-in-law. This put in lots of pressure and sometime they give in to please his mother but he is torn between his filial duty and cheating his future wife. Some NGOs' health workers are planning to intervene in this case but the issues are so sensitive. Everybody has right to marry even a hard core drug addict but his HIV status should be revealed to his future wife and safe sex should be practice and they should opt to being childless. The number of women who are not injecting heroin, are not commercial sex workers but are HIV positives are increasing year by year all through their sexual partners. This is because HIV positive youngsters are marrying without informing their wives. They fear that if they reveal their status, they will be rejected. There are many HIV positive couples who led a happy married life and they do practice safe sex. But their numbers are few. Condom promotion is being carried out only many IDUs (injecting drug users) and their sexual partners but the local population who are sexually active and who used the service of CSWs and female IDUs (injecting drug users) who are also solicit men for commercial purpose are also in great danger.

The HIV epidemic has been on for more than 14 years still there are thousands of parents unaware of the serious consequences of HIV/AIDS.

There are already instances of grandmothers and grandfathers looking after their grandchildren's, as both the parents have died of AIDS. But these are few instances. One grandfather said, " He loves his grandson very much and will do anything for him to have a comfortable life before he dies". So he goes out of his way doing things for his grandson who is four years old and suffering from TB and herpes. Both the boy's parents died of AIDS and his other siblings died before the age of two. The grandfather having lost his son, daughter -in-law and grandchildren feels that heroin should be banned from Manipur totally. It's a curse to our society says he!

The worse sufferers of this HIV epidemic in Manipur and elsewhere are the women, as seen from the experiences shared by them. The problems faced by the wives/sexual partners of IDUs (injecting drug users), alcoholic etc, problems of mothers, sisters, grandmothers, women who are affected by the virus (IDU/CSW), problem of village women, women leader, health workers, nurses, doctors. Shows that the entire burden of this epidemic are bore by them.

Emotionally and physically they are drained by the magnitude of the problem and fears for the new generation that are the future hope.

NGOs who have started the initiative to rehabilitation the widows of IDUs (injecting drug users) are already well known to the widows because the husbands were the clients of the NGOs. While they were ailing it were the NGOs staff and the peer educators who provide their medical needs and home base care, for at least a year or so. After their death the wives became dependent on the NGOs and they have no choice but to do something for them. In this ways the "self-help groups" for the widows of that areas which falls under the jurisdiction of that particular NGOs was formed. NGOs in Imphal has certain wards or areas that they take care of and in this way an overlapped is avoided. Many widows are poor so they do expect some financial support however small from these NGOs. Therefore the NGOs needs clients and clients need NGOs to function.

If we are to look at the distribution

of HIV positive cases in the eight districts of Manipur; given in (table 1.1), we will find that Churachandpur district shows the highest positively rate, followed by Ukhrul. This can be attributed to the fact that drug addicts in Imphal and the other valley district like Thoubal, Bishnupur have drug addicts who inject intravenously but since they belong to the higher status income group, they take precautions. They are able to take precaution and generally do not share the injecting equipment with their friends. Mostly they are able to afford new disposable needles and syringes every time they inject. So the rate of infection and the transmission of HIV virus through infected needles is less among them.

While in the tribal districts of Churachandpur and Ukhrul, the drug addicts share common injecting equipment which are soiled and re-used, by many drug addicts, who inject heroin in a particular place. Here the injecting equipment's are provided for all common use by the drug peddler who does not give a damn about the safety of these drug addicts. Even the drug addicts in Churachandpur do not mind sharing because usually they are very poor and careless about themselves. Moreover, initially they were not aware that sharing of injecting equipment among them would lead to transmission of HIV virus from one infected IDUs (injecting drug users) to another; because came to India only in the 80s

But like a sphinx she rose from the death from her sheer will power she rejuvenates herself for the sake of

Widow is generally termed as woman who has lost her husband due to death. The young widows of Manipur lost their husband due to AIDS or ARC (AIDS related complex) Diseases. IDUs (injecting drug users) in Manipur died an untimely death due to excessive abusing of drugs for many years. They used cocktail drugs by combining different drugs, they inject heroin, when heroin is not available, and they resort to chemical drug like proxyvon, tedigestic and alcohol.

Substance abuse has been a habit and a custom among the hilly tribes also for the Meitei community, who dwell in the valleys since ancient times. A local wine called "Zu" are brewed and consumed by old and young alike of both sexes. This rice wine brewing has been banned and stopped in urban areas, after Christianity came to the tribal people but in remote hilly region the practices still continues. Tobacco chewing, and pan chewing is a custom followed by all sections of the society. Pan parak, khaini and foreign cigarettes are found in abundance. So death occurring due to substance abuses is becoming a very common phenomenon in the state of Manipur. Manipur is considered to a be "Dry state" as far as alcohol is concerned but the number of deaths due to alcoholism among young male in the age group of 25 to 40 yr. old is staggering.

The destructiveness of Abusing heroin and alcohol's are only being felt in Manipur in recent years. It destroys marriage, breaks up families and friends; community and the impact of such addiction (deaths and widows) has manifested in the forms of many "young innocent' girls becoming widows as young as 18 yr. old and as old as 30 years old."

It also manifests itself in many societal problems like drug addiction, sexual behaviour problems, degrading moral values among teenagers, insurgency, broken marriages, dysfunctional families that are cropping up in Manipur. There are so many economic and social problems faced by the women in a poverty stricken state like Manipur but the problems of the widows of IDUs (injecting drug users) and of alcoholic are much more, for the simple fact that they are no ordinary widows. IDUs (injecting drug users) are looked down upon and are stigmatised by the society. Recently, stigmatisation has lessened to a large extent, because the number of drug abusers are still very large in numbers (estimated numbers by Manipur state AIDS society is 20,000 to 50, 000) but they are still considered "as burden, as parasites" by the families and by the society. Even the wives and children who get infected with HIV for no fault of theirs are discriminated and looked down by the society.

Table 1.1

General Statistics on Manipur State some Information about population, literacy, ethnic composition, religion etc.

State	Manipur NE
Areas In Sq.Km	22,327
Total number of districts	8
Total Population After 1991 Census	20,00000 lakhs
Male Population	938359
Female Population *	106141
Urban Population	1637504
Rural Population	362496
Distribution Of ST & SC. Population	36% / 2.30%
Numbers of tribes in Manipur	29
Hindu Population	57.67%
Christian Population	34.11%
Muslim	7.27%
Other Religion Including Jews	0.95%
Literacy Rate	60%
Community Development Block	31 villages
Number Of Villages	2035
Areas In Acres/Hectares under Shifting Cultivation	900
Village's Electrified	1721

Source: Manipur Statistics handbook 1997

*Female Population Is 961 Per 1000 Males In Manipur

Table 1.2
District wise distribution of HIV-positive cases

S.No.	Districts	No. Screened	No. Positive	Sero-Positivity	District %
1.	Imphal	25,071	4033	16.08%	69.16%
2.	Thoubal	3077	488	15.85	8.37
3.	Bishnupur	1,679	271	16.14	4.65
4.	Churachandpur	1,362	430	31.57	7.38
5.	Senapati	636	175	27.51	3.00
6.	Ukhrul	518	187	36.10	3.21
7.	Chandel	867	238	27.45	4.08
8.	Tamenglong	142	9	6.38	0.15
			3765 + 1237		

Source: Manipur State AIDS society

Annuxures 3.

Sushila a young widows of 30 years living in Imphal Manipur. Her point of views, which she wished to share with the world. (25.7.1999.)

My husband has been dead for two years now. He died in September 1997 of TB and other complication related to AIDS. While my husband was alive and not sick, we faced lots of social problems only because he was an injecting drug user. He was self-employed by doing petty business but we never have enough money to buy good things in life because a major chunks of his earnings goes in for heroin which he injects at least seven times a days. My two children have no good clothes to wear; they attend the local Manipuris medium school and were almost malnourish. I worked and tried to supplements the family income by doing odd jobs but that was not enough to put my sons in a good catholic school where he can read and write in English.

Life was miserable for, me we were not respected by our neighbours, families and friends. People of the locality were mean to us; even when I am in desperate needs of money, I can't finds neighbours and friends to lend me money. There are times when I feel that life could be so much better and easier without my drug addict husband and wished him death many a times but of course I want him to live for his children's sake, though he was not a good father to his children. On the days when he couldn't get his daily supply of drug he used to beat his children, while I was away on work.

Finally my husband started falling ill, with a minor complains and later he develops a lot of diseases and I was helpless. I had to work for a living, take care of him, feed my children. I was so desperate that when I heard about some NGOs in my area that are helping IDUs and giving medicines to sick IDUs. I decided to approach them. They visit my homes and some peer workers were known to my husband, even their doctor came and he was treated for some ailments. Each time he falls ill I call them and they take him to the hospital. The help provided by this NGOs lessen my burden a lot and I was free from tension regarding money and medical expenses. My mother in laws and her daughters refused to lift a finger to help and my children were in ill treated by them. Soon after my husband died of AIDS, he suffers for six months only but I felt like it was for years and I felt relieved at his death. I pawn my gold jewellery for his funeral expenses and borrow some money from his family.

I have not been able to satisfy the basic need of my children and this hurts me the most. I am unable to send them to school. All I think about now is how to live a simple life, how to improve my children's future. Also how to remain healthy but the tension is too much to bear, besides my neighbours gossip behind my back that I may be HIV positive and even my children will be, so taunts and discrimination in social gathering is still there. My kids are afraid to come out of the house and we face an uncertain future. Life is still a big problem for me and the burden has not lessen with his death.

What gave me some comfort is that there are so many young widows who have a similar problem likes mine. This I discovered only after joining the widows "self help group" where I went and shared my problems with the others widows. There was lots of crying and emotional outburst initially but I felt batter after such scene and come home happier. There are lots of plans to rehab and improved our lots but we have no financial support as yet, we are trying to do start small things like "friends credits" where we can generates small income for each of us. Without wasting any time they organised a workshop to gain more knowledge on HIV /AIDS. She wants to walk the normal path of life, wants to be normal again. A want to spend the rest of her life happily widows of IDUs needs help from NGO as well as from state government. Something should be done for us. We also need help from ACTIONAID

Annexure 4

According to one widow these are some points that need to be done if HIV infection is to be curb in Imphal.

1. After the "Self Help Groups " of widows are formed and registered as society, the first task they have to performed is to go for a house to house survey in each of the localities and identify the IDUs couples of that areas and invite them to join the MNP+ or the self help group.

2. They may face lots of opposition from parents of IDUs and from IDUs couple themselves but the widows have to be strong and persist in their venture.

3. All the IDUs have to be identified before they get married so that the young innocent girl can be warned in time, Preventative care and palliative care should be provided to Sick IDUs.

4. All identified and known male and female IDUs should be compulsorily tested for HIV.

5. Wives who are HIV positive should be provided with medical and psychological supports from NGOs and GO.

6. If all the male IDUs go in for HIV and take precaution, then the chances of the epidemic coming down is possible and many more women will be safe from contracting this virus, Male IDUs needs to be more responsible.

7. Community focus group meeting and workshops are not the right forum to spread the message, it needs to reach more people of the grass root level, and otherwise awareness will be confined to only some section of the people.

8. If more positive people come out in the open then the number of women and children getting infected will be less.

9. Orphans of all IDUs couple should be given all types of facilities, so that they can have a better life and become better human beings by following the right path.

10. Widows of IDUs wants to lead an AIDS free life

11. Youth and adolescent should be given health education Programme in schools and colleges so that they can become a better citizen of our state.

12. Young innocent girls should be made aware of the

13. Windows of IDUs should be trained as care giver, as they have already experience giving care to their husbands. More training Programme for them

14. Self help group of widows needs to have permanent housing facility for them to meet and discuss future Programme

Annexure 5.

A young widow's anxiety!

After my husband death what I fear most was the social stigmatisation as I was social person. I was afraid to be mocked and laughed at by the neighbours so I confined myself to my home. Whenever there is social function, I was not invited even if I am invited I avoid attending as I felt inadequate among the other young women who are still married and happy.

She suffers a lot because of her isolation and has no one to take care of her when she falls sick. Her small daughter cannot even prepare a cup of tea for her while her In-laws ignore her. She is financially very poor and has no one to help her when she needs money and is afraid to borrow from others.

She has to be self-reliance and need to take care of her child who is three years old.

Sometime she does odd job like going to the rice mill and cleaning the rice, for which she earns 30 rupees a day and she spends it on food alone and has no extra money for clothes.

She minds that her child has no father to talk too and is very lonely as other kids avoid him.

She sufferers from an inferior complex and cannot answer back when people are rude to her. She just keeps quite and people have taken advantage, as she is a young widow. After she joins the "widow self help group" she is fearless and is ready to face any problem or obstacles that comes her way. She is ready to take care of her future which a she wants to be a good one, Now she can defends herself if people are rude to her. After being a widow for four years now she does not want to be married again even if she is young .Now her priority in life is to established her son 's future and make a proper man out of him. She wants her son to be the exact opposite of her husband and be a successful man in life and take care of her in her old age.

Her other job is to ensures that young girls in Manipur do not suffers the same fate as her, this she intends to do by forbidding young IDUs men from getting married, at least in her locality. She knows who are the IDUs, in her neighbourhood. She has already prevented one young girl from marrying an IDU by informing the girl's parents about his injecting habits and about his HIV status. This she say she has very right to do so because male IDU cheat their wives and lie to them before marriage. According to her it's better to remain unmarried than be a wife of an addicts. Life is hell with them and why is a young widow at 22 years when there is a full life ahead of me. I am not satisfied with the way my life shaped out. I am full of regrets in life.

Acronyms and Glossary

AIDS : Acquired Immune Deficiency Syndrome
ARC : AIDS Related Complex
Asymptomatic : People diagnosed as being HIV+ but who live a healthy life
CSD : Centre For Social Development
COCP : Continuum of Care Project
CSWs : Commercial Sex Workers
HIV : Human Immuno Deficiency Virus
IDUs : Injecting Drug Users
ICHE : Involvement of Community for Human Empowerment
Phanek : The traditional attire of a Meitei Hindu Manipuri ladies
Puan : A Paite term for a traditional attire worn by Paite ladies
Kasubis : A derogatory term used to refer to a woman of loose character
Zu : Locally made liquour made out of rice extensively consumed by Manipuris. Hingminabha : Manipuri phrase which means "to survive together"
HOPE : Horizon Of Prosperity and Education, an NGO
ISD : Institute for Social Disease (Manchin, please check this)
Imphal : The capital city of Manipur
ICMR : Indian Council of Medical Research
Churachandpur : the second biggest town of Manipur, the headquarters of the southern districts
SASO : Social Awareness and Service Organisation, an NGO.
Symptomatic : HIV positive people already showing the signs and symptoms of AIDS
MACS : Manipur AIDS Control Society, a quasi NGO.
MNP+ : Manipur Network of Positive People
Meitei-lon : Most common language spoken in Manipur
Meitei : The dominant Hindus of Manipur who inhabit the plain areas.
NGO : Non Government Organisation
NH # : National highway Number
GO : Government Organisation
Paite : A tribal dialect of the Chin group spoken only in Churachandpur district.
PRAM : Physicians Responsible for AIDS Management.
Hmar : A tribal dialect spoken in south district of Manipur.

MONOGRAPH 6

Changing Faces of Drug Scene

- *The other side*

Molly Charles[1]

Association with mind-altering ubstances has undergone changes with e introduction of punitive paradigm of rug abuse and its management. This ift necessitated the formation of new ocial constructs to define drug, drug use, rug user and the drug dealer. Use of ind-altering substances is a historical henomenon in India. Only since middle f 1980s, it is perceived to be major ocial problem. This paper deals with the arying shades that emerged in the erception of drug use or abuse.

) Cultural schema for understanding drug effects

The socio-cultural constructs that xisted with regard to drugs, drug user, rug experience and control mechanism re different from what is being isseminated through media and many rug programmes. At present many ocial constructs[2] portray the 'drug' as eing a fiend that overpowers the elpless human being and makes him/her nto a slave. This is far removed from ow the society viewed/views this henomenon.

The present drug abuse management philosophy is vividly different from cultural mechanism that existed in many cultures and continues to persist in some in spite of criminalization. Unlike the earlier forms of use, the contemporary 'marijuana habit' differs sufficiently in expectation motivation, patterned responses and life style of users –to constitute a distinct subculture (Rubin, 1975, (258-266). At the same time in earlier societies (Wilbert as cited in Rubin, 1975), observes that there is an obvious cultural conditioning towards specific ecstatic experiences that have nothing to do with the chemical action of the tobacco plant'.

In many instances use of psychoactive substances had much more to it's use then dealing with day-to-day living. According to Myerhoff, use of peyote was a means for external unity, whereby barriers between self and objects disappear. "It evokes the timeless, private, purposeless aesthetic dimensions of man's spiritual life, mediating between former and present realities, and providing a sense of being one people despite dramatic changes in their recent history society and culture (Myerhoff, 1975). It is the same state that is defined in Mandukya Upanishad (1957) "... It is one without a second'.

Evident difference in the social constructs that emerged through the years in various cultures and the present western perception that governs the drug abuse management is illustrated by Myerhoff remark. He said that 'It would be profanation to discuss Huichol peyote use in terms of kicks, high and escape and the other terms which describe the goals of individuals drug taking outside of an integrated cultural setting'. Probably years ahead there may be serious discussion of hallucinogenic drug use as a threshold to paranormal phenomena and 'may find verification that indeed primitive man had inside track in some areas whose present validity is subject to doubt' (De Rios, 1975).

Since, psychoactive substance is not a recent invention of man, it is natural that through the years different cultures evolved their own framework to deal with use of such substances. One of the important aspects of such use was presence of rituals and the constructive role it played. It is interesting to note that the present drug literature talks about role of ritualization and need to consider mediation of drug effects by set and setting especially with regard to harm minimisation programme (Grund, 1993, Zinberg, 1999). In the past writers had put forth the significance of these aspects in use of psychoactive substances in traditional societies. They also pointed out that in addition to set and setting actual drug effects are mediated by host of additional factors such as belief systems and values connected to psychoactive plant use. According De Rios (1975) these antecedent variables interact with the consequent relation of the drug. It is only subsuming the antecedent relation under general principles, which relate to previously established antecedent-consequent relations that one can attempt to predict new or not- yet verified relations and obtain useful theory of drug effects.

Given the lack of shared paradigm De Rios (1975) puts forth concatenation schema, which looks at the interaction of antecedent and consequent variables (Aneex 1)

Under antecedent variables are four general areas are biological, psychological, social-interactional and cultural. It has been noted that during ritual use of peyote for spiritual journey, members focus on their physical condition, diet and sexual abstinence (Myerhoff, 1975). This is also seen in case of sadhus from India (especially Naga and Aghori sects) who live in isolation, maintain special diet, abstain from sex to facilitate their communion with their Lord Shiva (Charles, 2001a). Use of specific food has also been part of the cultural consumption of opium among Rajputs (Charles, 2001a and Masihi et.al. 1996). This according De Rios, 1975, creates a situation where "The main effect of sexual restraint and particular diets and food taboos, at

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This paper produced under UNESCO - MOST India programme on drugs (www.unesco.org/most/drugs.htm)

[2] There are many stereo-types promoted along the Western perceptions: 'Drugs Kill'.

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another level, however, seems to be to shroud the actual experience in an aura of the unusual, the special, the non-ordinary". As a result "when the initiate or shaman comes to the experience, his expectation of entry into distinctive realm of consciousness is high, and he is, in effect, psychologically as well as physically prepared for the experience"... (De Rios, 1975).

When a user undertakes this rigorous journey to utilise mind altering substances towards attaining 'peak experience' as described by Maslow[3] 1(1970) and the use of drug is as a catalyst or symbol. When used for ritual purposes, Peyote use is symbolic. Even in case of sadhus who use drugs extensively the focus is not to become disoriented through drug use but to channel the experience to be close to God. Besides, among Sadhus becoming disoriented through use of drugs is considered to be an insult to their Lord. Through rituals, users experience are channelled and drug in itself becomes a part of the entire process to attain their goal. The importance of other aspects are emphasised such as role of a guardian/ guru, role of physiology, role of commitment to attain the goal whereby the individual is willing to go through many hardships to attain the communion (Charles, 2001a).

In area of psychological aspects, the factors that contribute towards drug effects are motivation, attitudes, personality, mood and past experiences. In earlier societies and even today in certain states in India, with regard to certain substances, motivation to take the psychoactive substance is moulded by the cultural values and as a result it shapes the attitude towards drug use and user. Drug is seen as part of enjoyment in Holi festival and as a part of religious celebration during Shiva Ratri, during that day the priest of Lord Shiva's temple distributes it as prasad.

Drug effects are determined by the structure of the group, the relationships of the members present, their role interactions, rituals performed and presence of a guide. In the case of cannabis and opium use in the Indian context it has been seen that the presence of older members in the group, ensures that a watchful eye is there on younger[4] members (Charles, 2001a). As the drug is consumed in-group setting and the group shares the substance, there is an indirect control on amount consumed at a time. In addition to this through rituals the user is oriented to mode of consumption that has proved to be less harmful, as loss of control is discouraged. For example while smoking cannabis through chillum the smoke is exhaled, unlike the pattern documented in non cultural society where the focus is to retain it to for a longer period and also to consume larger quantity during a single session (Green et al 1975). Past experience of older members is used as guide to acquaint the users to the psychoactive drug experience. Deviation from the accepted path is discouraged through stigmatisation but not alienation. This process of control becomes easier as the deviant behaviour is not pushed underground or considered a crime. These factors restrict the use of psychoactive substances to certain occasions, for specific ritual and among specified group gathering. This probably explains the reason for controlled use of cannabis in many cultural areas in India, where cannabis is acceptable for religious and social purpose (Charles, 2001a).

Enculturation plays a vital role on the effect of the drug experience. In case of religious use of cannabis, religious precepts are strengthened and deviation from it is seen as an insult (Charles, 2001). Shared symbolic values are crucial to achieve culturally valued goals, especially those that are raison d'etre for non-western cultural experience. It is prior socialisation in this area, which forms the basis for shamanic success (De Rios, 1975). The role of shared symbolic value is also seen in cannabis use for religious purpose, it is evident from Hindu mythology and rituals that surround religious consumption of cannabis. Use of colour (Holi festival), music (bhajans for religious meet and music during Holi) and pleasant odours all from a part of cultural use. Though there has been changes or deviation in use by some individuals, by and large symbolic value with regard to cannabis use still persists and cultural forms of control still exists.

In the Indian situation of cultural use with regard to certain substances cannot be dismissed as esoteric knowledge applicable to certain groups. For cannabis use within cultural realm still hold true for certain States dominated by Hindu way of life. Besides the reality that in many parts of India substance use has been curtailed or restricted to use of soft drugs make it vital to give it serious consideration especially in the context of evolving socio-culturally relevant harm minimisation programme. It is this enculturation process that has prevented the spread of hard drugs in spite of the monetary benefits in marketing harder drugs with better profit margin. Of course, this is not the case in cities where drug market strategies is slowly creating space for harder and newer forms of drug use.

Cultural Base for Drug Experience

Cultures across the globe have provided space for use of different forms of substances to be integrated within the cultural framework. It has been undertaken for different purposes ranging from strengthening human beings links with supernatural world to health care and relaxation. While providing scope for use, there were mechanisms in place at the formal and informal level for control and restriction of any deviation. Here an attempt is made below to elaborate how culture contributes towards drug effects.

Experiencing Altered States of Consciousness [5]

Drug use has been a part of human being's drive to experience altered states

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[3] According to Maslow's, 1970 description of peak experiences with regard to religious experience, `that is states of ecstasy , human beings may become non-striving, non wishing, asking less for themselves, becoming more unselfish... They become more God like.

[4] This has been used by Manakalo opium deaddiction centre as strategy to ensure that ex-addicts do not get back to drug use.

[5] This section has been extensively focussed as the author believes that it has not been adequately addressed and without dealing with it no meaningful drug abuse management can be arrived at.

f consciousness. There have been many nechanisms to attain that status be it nrough yoga, meditation and nvolvement in certain activities in the rea of religion/spiritual sphere of life but se of chemicals of various forms has een a integral part of the drive for ltered states of consciousness (Tart, 990). Yet, there has been hardly any ocus on this drive or its channelling, at he most drug abuse programmes ndirectly scorns it by highlighting the egative impact of drug use as a result f socio-economic costs involved at the evel of the individual and society.

Historical reality states that drive for altered states of consciousness has been moulded by many cultures thereby creating social constructs with regard use of mind-altering substances and those who consume it. The drive towards experiencing altered states of consciousness has been applied towards enhancing human understanding of existence and for purposes of maintaining or strengthening existing social structure[6].

The use of mind-altering substances for religious purpose within communal setting has been documented in various cultures. Hemp was used in religious rituals, temple activities and tribal rites, involving people rather than the solitary individual. The pleasurable psychoactive effects of hemp were then, as now, communal experience (Benet, 1975). Rubin, 1975, wrote on ganja use in Jamaica as: "The ganja vision is a culturally standardised phenomenon occurring generally at the time of first smoking experience, confirms the role of the smoker. The phenomenon is compared to the institutionalised vision quest among American Indians of the plains. The vision phenomenon, a culturally patterned experience with standardised content, usually in the context of a rite de passage, thus differs from idiosyncratic hallucinatory experiences. Hallucinogenic reactions are neither generally sought nor experienced by working class males in Jamaica".

Among the South American Indians tobacco is used mainly for magico-religious purpose, and only in recent historic times has the manner and ideological foundations of its use shifted increasingly from magico-religious to the profane. Liquid form of tobacco is of great magico religious significance in Montana region and Guyana. To illustrate this case, among the Jivaro of the Monata ritual tobacco drinking is especially elaborated and institutionalised. Jivaro consume tobacco water in order to acquire an arutam soul and to be enlightened by a particular spirit concerning their fortune in warfare and life in general. Towards this end young men in particular often leave their villages in small bands to retire into solitude to a special 'dreaming-hut' that has been constructed for that purpose away from the village in immediate vicinity of the waterfall. During their stay, which last for several days they restrict their diet to tobacco, drinking it in large quantities. In the mornings they exchange their dream experiences and interpret their visions. Only after several days do they rejoin the community as a whole, physically emaciated but psychologically reinvigorated. For these people "tobacco served as a bond of communion between natural and supernatural worlds, as it were as the actualizing principle between the two" (Wilbert, 1975).

According to Myerhoff (1975) among Huichos, a worldview is elaborated, based on the use of peyote. It is cultural expectation for their hallucinogenic experience along with recurrent possibly pan-cultural mystic vision that provides a touchstone for this worldview. "This worldview emphasises on overreaching a total unity, in human relations, in man's relation to his natural and supernatural world, in his understanding of his history and ultimate destiny". To attain this spiritual state the person goes through a ritualised pilgrimage that lasts for several weeks. During this period peyote is eaten or drunk ritually and in quantities insufficient to obtain vision. It plays a symbolic role in achieving a kind of communion with deities. In addition to this pilgrims endure many privations, they forego or minimise human physiological needs as much as possible sleep, sexual relations, excretion, eating and drinking are actually or ritually foresworn during this period, for those are activities of humans not Gods.

Religious use of mind-altering substance is not alien to the Indian context, especially association between Soma and Lord Shiva. There has been dispute as to the actual botanical nomenclature of Soma, some considered it to be mushroom fly agaric; others affirm it to be Asclepias acide or Strophoria cubensis or cannabis. It is possible that Soma mentioned in Rg Veda is a creeper plant or rather the moon-plant with intoxicating juice to be drunk at sacrifices or special occasions. Even in early times, documentation shows Risis permitted to perform sacrifices involving the use of Soma, because scarcity of Soma substituted it with another creeper plant. Since the Soma plant is rare, the more abundantly available cannabis must have been slowly associated with it. At present the religious symbolic association with cannabis is well illustrated by the idol of Parappaswamy a holy man, who used cannabis to enhance his religious insight. His idol, represents him smoking cannabis and is worshipped by people in the Dommasandra, a village in Karnataka (Charles, 2001a).

Among the religious personalities who worship Lord Shiva, especially sadhus, cannabis plays an integral part in the initiation to Sadhu life and subsequent process of graduating beyond using drugs for meditation for communion with their Lord. The neophyte who enters at a young age (early teens) is trained

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[6] The case study of opium use by Rajputs, undertaken by Masihi, et al, (1994) shows how during the dayro session along with consuming opium verses are recited about the virtues of political leaders and also bravery of those who fought under their command. In the process it also strengthened the loyalty of the warriors who participated in these sessions.

[7] Drugs consumed by sadhus include ganja, charas, dhatura, snake poison and scorpion sting, and often smoked in combination. To consume a mixture of five drugs at one go, the sadhus use a special chillum called Mahachillum. This pipe has five funnels, centrally connected. Each funnel contains one of five different drugs mixed with tobacco namely, ganja, charas, dhatura, scorpion sting and snake poison. Mastery of the act is gained by first taking each of these drugs separately in large quantities and then taking them in combinations of two, then three, four and five. An extremely rigorous process it is always done under the guidance of an experienced guru. The Mahachillum is smoked on rare occasions, such as Shivaratri, death of a guru or any major religious meetings. A Sadhu who has smoked the Mahachillum is held in awe by rest of the sadhus

to say prayers, do yoga and take cannabis. The neophyte is trained by his guru on how to use drugs: which includes how to clean a chillum (pipe), how to fill it, how to control the breath and exhale, the spacing between inhalation and exhalation, to deal with the mind if the drug consumed is excessive, and to deal with over intoxication. This training is undertaken more diligently in the case of drugs[7] considered more powerful than ordinary ganja.

Religious and cultural use of cannabis has not been restricted to sadhus, for religion played a significant role in moulding cultural use of cannabis. Use of cannabis within the Hindu religious context has been documented in Puri (Ray,R,1989) and in Varnasi (Tripathi,S,1989). Other than in Hinduism, use of cannabis has also been documented in the tradition of Sufism (Mehraj-ud-din, 1989).

Altered states of consciousness is not merely a 'high or escape' as the present drug literature represents. De Rios (1975) states "Individuals who are reared in a society where hallucinatory drugs have been used traditionally, enter a drug experience with certain expectation about the content and form of drug induced visionary experience, this is especially so when specific beliefs are held and individual experience is programmed by skilful shaman or priest". Use of mind altering substances in different cultural setting illustrate "... cultural variables such as belief systems, values expectation and attitudes contribute to the structuring of one of the most subjective experience available to scientific inquiry".

Pragmatic application of mind-altering substances

Mind altering substances in combination with other substances and in isolation have been used for medicinal curative and preventive purposes in many parts of the globe. According to Myerhoff (1975), peyote is used medicinally for a multitude of problems, eaten to relieve pain, made into poultice and applied to wounds. It has also been taken for energy endurance and courage. Among the Huichol it is used as panacea.

The same situation is seen in other cultures with regard to different psychoactive substances, such as opium or cannabis. Usage of cannabis for medicinal purposes has been documented in Nepal (Fisher, 1975), India (Chopra,et.al.,1990, Charles, et al. 1999) and in China (Hui-Lin-Li, 1975). In Nepal cannabis is used extensively to treat human and animals in the indigenous medical system. It is an ingredient in compounds used to treat diarrhoea, cholera, tetanus rheumatism and insomnia among many other maladies. It is also employed as a cough suppressant, digestive aid, and stimulus to whet the appetite, soporific, aphrodisiac and anti-malarial agent for hill people who move to Terai. Similar forms of use have been documented in different types of traditional systems of medicine practised in India. In China the famous physician Huo To' (110-207 AD) used , ma fei-san (hemp boiling compound) to be taken with wine to anaesthetise his patients during surgical operations on abdominal organs (Hui-Lin-Li, 1975).

Other applications of psychoactive plant products have been for fibre, oil and food. Among all psychoactive substances, cannabis plant has been used for many purposes other than its psychoactive nature. For textile fibre three centres can be recognised in the ancient old world: the linen culture in the Mediterranean region, the cotton culture in India and the hemp culture in Eastern Asia. Evidence of the use of hemp fibres has been found in Neolithic records in northern China. While silk fabric was used by the wealthy, hemp cloth was the textile of the masses. Hemp fibre was also used in paper production, an important contribution of Chinese culture to mankind. Paper originated in China in the late Han Dynasty and it was produced by Hou-Hanshui using old fishing nets, ragged clothes, hemp fibre and tree bark. Fishing nets and clothes were also made of hemp fibre (Hui-Lin-Li, 1975). Use of cannabis plant for production of fibre products such as jackets and shoes exists in Himachal Pradesh (India), though it is soon losing out to cheap plastic products (Charles, 2001c). While local production is losing its clients, there are hemp jackets (designer made) manufactured in developed countries using raw material from Asian region available at curio shops for exorbitant prices. Hemp jackets are extremely useful for cold climates.

In addition to manufacture of fibrous products cannabis is also used as food. In China, cannabis was used as food, and hemp seeds were considered along with millet, rice, barley and soybean, as one of the major grains of ancient China (Hui-Lin-Li, 1975). In Dolpa district of Nepal cannabis is neither used ritually or socially nor medicinally. At the same time it is extensively cultivated, but it is never used as an intoxicant. The seeds are extracted from the rest of the plant and then pressed into a dough-like pulp. The dough is then kneaded at a top of a slanted washboard type surface so that oil is squeezed out and drains to the bottom of the board where it is collected. This substance is used for cooking, and is the main source of cooking oil in this area of Nepal. Without this oil preparation of food would be impossible. The people here, especially Magars, never smoke ganja or charas (hashish) and cooking oil has no hallucinatory effects (Fisher, 1975). The use of cannabis plant for cooking oil is also seen in certain parts of Himachal Pradesh in India (Charles, 2001c). Other countries have also been involved in commercial manufacture utilising cannabis fibre for mercantile purposes, such as Russia, Canada and United States.

Psychoactive products form a part of festive celebration in many cultures. In Nepal, cannabis is used during celebration of Shiva Ratri. During this period, prior to criminalization of cannabis use, enormous number of pilgrims gave cannabis as prasad (gifts) to sadhus. Another occasion for use is the Krishna Ashtami (Lord Krishna's birthday), when school children are also given permission to use cannabis drink (Fisher, 1975). Similar forms of celebration are also seen in India (Charles, et al, 1999). In addition to this, in certain parts of India, it is an integral part of marriage celebration and other social occasions (Rao, 1996). Besides cannabis, opium products are also used as part of celebration is various religious and social occasions (Masihi, et al, 1996).

II) Adding economic Value to mind-altering substances

Trading in mind altering substances in large scale for maintaining country's economic base has been undertaken at

different times by many countries and has been seen in the dealings of colonial countries especially prior to the Second World War. Tracing the history of such incident can give a better understanding of the growth of the construct of drug abuse management or trade for monetary purpose.

In certain parts of the Asian region opium production and trade has been part of their life for centuries, but large-scale efforts as an economic trade was not common. During the rule of Moghuls both in India and Pakistan opium production was controlled for tax revenue purpose, but it is under the British that opium and cannabis flourished. The British East India Company created an opium monopoly and extended incentives to greatly expand production and consumption. The British organised and expanded the opium trade with abandon; their only major resistance came from China. Which resulted in the humiliating Opium Wars 1839-1842 that effectively cowed the Chinese and thereby left the field open for British expansion in opium and trading in other products. Whenever required the British used military means to enforce their drug distribution monopoly (Charles, et. al., 1999; Buddenberg, 1993, Britto,2001).

Under international pressure the British tried to sing a different tune and this became more evident after Pakistan became independent in 1947. For Pakistan began to license opium production as the British did and this was not acceptable to the British, who joined other countries to create international pressure to turn Pakistan around. Subsequent civil war in neighbouring Afghanistan further complicated the situation (Buddenberg, 1993). For global player, then Soviet Union wanted to move into Afghanistan and local religious fundamentalist group received support from another country interested in restricting the spread of communist ideology in a covert manner[8] (war on behalf of freedom, or rather the freedom to restrict the spread of different ideologies). According Muhammad (1998) the resistance movement in Afghanistan contained a number of people who used heroin trade as a means of personal profit, to purchase arms or to replace misappropriated foreign aid. Slowly Pakistan became a base for heroin processing from opium produced in Afghanistan (Buddenberg, 1993). In addition to targeting at export, to create local demand artificial scarcity of traditional drugs was created (Muhammed, 1998).

History also illustrates how dealing with mind altering substances emerged as a result of economic crisis that occurred as a result of insensitive trade policies that provided temporary social mobility at a speedy rate. According to Partridge, 1975, in Colombia Municipio there are legal and social sanctions against the cultivation, sale, and the use of cannabis. Decree 1699 of 1964, Article 23 dictates from 2 to 5 years of incarceration for cultivation, distribution, sale, use or possession of cannabis. Article 24 prescribes 1 to 4 years of incarceration for the same offences regarding any kind of estupificante. Though it is recognised that cannabis is totally prohibited by law, most of town people, public officials and growers simply look the other way at cultivation for it brings in United States dollars into Colombia.

In Colombia, cannabis cultivation and marketing are placed in the same class as contraband in which most upper sector persons play some role. Commercial cultivators are drawn from the prosperous cachao peasants, who are by and large advanced in age, well established and highly respected household heads. This was not the reality of Colombia, prior to the grave economic crisis throughout the coastal subculture that occurred as a result of abandonment of the banana zone[9]. With the economic crisis some people especially those who had been exposed to social mobility began to cultivate cannabis as a cash crop in the rugged terrain.

III) Redefining the philosophy of drug abuse management

Punitive paradigm towards drug abuse management began in 1900s in America and through the years the approach got strengthened and also formed the basis for global drug policy. The first act regarding narcotics to be enacted was Pure Food and Drug Act of 1906, which required label of any patent medicine to list all narcotic and cannabis ingredients. This step was taken as a result of pressure from reformers and medical community (Bertam, et al. , 1996).

Another force that gained ground was puritan approach, which was a crusade

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[8] *For America freedom to restrict the spread of communist ideology was important. It is this that made them fund and facilitate the movement of nearly 25,000 Islamic militants from different countries to Peshawar and then to Afghanistan, when Soviet invasion of Afghanistan took place. In 1986, CIA got US congress to supply Afghan mujahideen with sophisticated weapons and allow American personnel to train Afghans in covert warfare (Abheek Barman, The Economic Times, 25 Sept, 2001.*

[9] *Banana boom began with United Fruit company setting up a base from the year 1986. During the peak period that lasted from 1915 to 1943, the local living condition changed drastically. The cultivating area increased to 30,000 hectares and local area was improved by building better roads, bridges and housing facilities. There were workforce from the management level brought in from America, France and Britain by the US capitalists and the workforce of labourers from different parts of the region. During this period seeing the speedy accumulation of wealth landowners that were operating tracts of cattle and sugarcane also converted to banana growing. The year 1943 saw a shift when as a result of World War II no ship reached the ports of Santa Marta Later the Company came back in 1947 to restart their operation and found that their land had been invaded by wealthy private producers and landless labourers. This led to them negotiating a new policy with Colombian government, whereby contracts where signed with the wealthy private producers, as tenants of the land and peasants were ignored. As per the new contract the tenants had to sell all their entire banana to the Company and to pay US $ 1 for each hectare not cultivating banana. The export rose far beyond that during the earlier boom period. But, around this time the company began to liquidate its holdings in Colombia as a result of changed world market. By the year 1964, the Company owned no banana producing land*

With the exist of the Company the Municipio saw the exit of wealthy plantation owners much of the middle sector employees and hundreds of workers Many families of the elite and middle sector were ruined (some of the exposed to elite life style, with children studying in Europe and United States). The workers lost an income that provided the impetus for migration, for the company offered a better scale than otherwise available to them

against vices-drinking, gambling, prostitution. It also had a tinge of deep-seated racist and nativist fears, for there was wide spread concern regarding migrants population especially Blacks, Chinese and Mexicans. An appellate court in Oregon openly acknowledged the racist prejudice by concluding " Smoking opium is not our vice, and therefore, it may be that this legislation proceeds more from a desire to vex and annoy the `Heathen Chinese' in this respect, than to protect the people from the evil habit' (Bertam, et al. , 1996).

The step towards making punitive drug strategy an international agenda came into place in 1909. Initial reason for an international perspective was that United States had no clue of how to deal with large number of registered users of opium in Philippines after it gained control as result of Spainish American war. At that time the solution offered by Reight Reverend Charles Brent, the Episcopal bishop in Philippines was to call an international conference on regulating opium trade. This led to prohibitionists wanting to reduce supply and thereby hoping to control domestic drug problem, they sought Washington to support an international agreement to ban the production, export and use of cocaine and opium abroad and also pass federal legislation to ban all imports of these drugs. The reason given to gain support of the democrats, who were hesitant to cede to Washington police powers reserved to the State was that cocaine is often a direct incentive to crime of rape by Negroes of the South and other sections of the country (Bertam, et al.,1996).

The latter period saw the slow development of punitive approach that believed force was needed to control supply and demand side of drug sue. Harrison Narcotics Act, 1914, which had provision for ensuring addicts got their substance under guidance of medical profession was changed drastically when Treasury Department was made in charge of administering the Harrison Act. The treasury department was not happy that medical professionals were unable to cure addicts and they ensured all clinics were closed for such activities. Slowly marijuana also became included as an illegal substance, under the assumption it encouraged crime and addiction (Bertam,et.al.,1996). Cannabis was included in the list of banned drugs out of political pressure and not based on scientific data (Britto, 2001). Inclusion of marijuana in the list had to do with use of cannabis products by certain members of the Hippie movement, they used it as a mood modifier in daily social interaction. After World War II link was established between drugs and threat of communism in order to sustain punitive approach. It was stated that Red China wanted to destroy the Western society. The ardent propagator of punitive paradigm was done by Federal Bureau of Narcotics and its first commissioner Harry Anslinger (Bertam, et al.,1996).

The shift towards treatment and prevention came during sixties under the President John F Kennedy, who along with others secured resignation of Anslinger as FBN chief. Emphasis on treatment as an option to deal with existing users gained support with emergence of vast federal health bureaucracy. Within treatment programmes different approaches emerged but no interest was shown by treatment professionals to question the basic contradiction that continued to persist, for overall emphasis on punitive paradigm continued. With time treatment and prevention became a soft adjunct to overall war on drugs (Bertam, et.al.,1996).

The history on evolution of punitive paradigm in America shows that there is nothing natural about the conventional wisdom that informs the current approach to drugs. The punitive paradigm is a product of protracted political struggles that set the agenda for an increasing impoverished and narrow public debate (Bertam, et.al.,1996). In spite of absence of any sound foundation for punitive approach, America with its political clout ensured not only its implementation in its own country, but also coerced (if necessary) developing countries to fall in line with its strategy.

IV) Implication of new definition of drug use and drug trade for drug abuse management

The creation of uniform philosophy for drug abuse management was an attempt towards cultural convergence whereby cultural differences are overridden. The attempt was to criminalize all forms of use of mind altering substances other than for medical purpose but in the process it not only criminalized all forms of cultural use but also cultural mechanisms based on local wisdom that evolved through the years. This task has not been easy achieve because of the difficulty in changing culture and also because of the limitation or flaws within the punitive paradigm that emerged as means for drug abuse management.

Culture is not easy to change; the task is made difficult when the goal is to eradicate cultural differences, be it only for one specific behaviour. As culture is not static it does provide scope for human to modify conduct by changing the guides, rules or plans and adjusts but change depends on other factors. Some of the hurdles towards this change can be economic obligation involved in adaptation or resistance to change, tendency to converse cultural norms and extent of integration which act as impediments to change and the emotional attachment to customs (Barrett A, R, 1999).

By making psychoactive substances into contraband the legislation did create an economic advantage in accepting change. This advantage was not in terms of giving up drug use, but rather in marketing the various types of substance termed as contraband. It is this that facilitated in creating local peddling networks that marketed drugs outside the earlier frame for dealing in psychoactive substances. For example in Mumbai street level peddling some of earlier dealers in cannabis and opium closed shop or shifted to other business, or continued to deal in traditional forms of drugs in small scale (a small percentage) and or shifted to brown sugar sale. By and large to deal with the new drug heroin, a new group of dealers came into picture especially those who had direct or indirect links with criminal networks. This process of change did not occur overnight, for initially brown sugar when introduced to market was sold by many of the old time dealers but seeing the users go through rough time some of the deal-

rs either stopped dealing or shifted ack to dealing in cannabis and opium. As one of the dealers stated he found t difficult to see cannabis and brown ugar in the same light for in case of rown sugar he could see the user deeriorating in front of his eyes Charles, et al, 1999).

Brown sugar is claimed to have entered the Bombay market around 1984 and then subsequently became well enrenched. The initial period of shift from cannabis or opium to brown sugar was said to have occurred as the police were active in the streets of Bombay as a result of political disturbance that resulted from Sikh assertion against central government. Later, the introduction of NDPS Act (1985) may have played a crucial role in ensuring the base for heroin sale. For with the introduction of the new law all drug were given the same status with regard to sale and as a result dealing in brown sugar became viable as a business proposition then dealing with cannabis and opium. Brown sugar provided more profit to the dealer who could easily satisfy the needs of corrupt officials and also brown sugar is far more difficult to detect (Charles, et al.,1999).

Another hurdle for cultural convergence with regard to drug use is tendency to converse cultural norms. The extent to which it is integrated within the system determines the hurdles in bringing about change, especially when there is emotional attachment to these norms. This explains why cultural use is the predominant pattern of use in many parts of India, though with certain modification. In fact to implement the law in its true sense would require huge prisons (Rao,1996). Thankfully the human machinery and non-legal institutions have been far more realistic in their approach to drug abuse management. Thus, it is areas where NDPS Act has not been implemented in its true sense that has managed to ensure harm minimisation approach within socio-cultural reality persisted. The question is that how long will it continue before these areas also given in to economic advantages from shift to marketing harder forms of drugs. The shift to harder forms of drugs cannot be prevented unless and until the drug abuse management programme acknowledge the relevance of formal and informal norms that has been nurtured by culture for years.

Flaws that exist within the existing punitive paradigm is another factor that ensured the failure of war on drugs and also created more harm then intended. The impact of drug war on drug abuse situation in America is taken as an illustration for America has been very vocal and active in propagating war on drugs within their country and at the international level. According to Bertam,et.al.,(1996) the main aims of the drug war syndrome was to:

- To prohibit supply so that users cannot find or cannot afford use
- To discourage those who consume drugs by penalising them
- To increase risks (legal, social and occupational) related to drug use and drug possession
- Reducing supply of drugs by restricting growing, manufacture, distribution, and sale of illicit drugs, thereby making drugs so scarce that high price will lead to reduction in drug consumption.
- Greater emphasis on enforcement programmes and making prevention and treatment programmes a minor side show in the larger drug strategy. For example the expenditure on enforcement in 1992 crossed 12 billion, expenditure on research was less than a billion and expenditure on treatment and prevention above four billion. Even in the area of research, programmes that are funded are those promote the government drug strategy and not those that seek knowledge to evolve a rational approach towards drug abuse management.

The main drawback faced by war on drugs is that it is misconceived and so will continue to fail with best of human resources and large budget. In spite of spending huge amount of money on drug control, the number of heroin addicts jumped tenfold and cocaine use, which raised few concerns in 1967, claimed at least 2.1 million hard core addicts by 1993. One of the flaws in war on drugs was that it failed to give adequate consideration to profit paradox, whereby the success in artificially raising prices also inflates profits. These high profits have a paradoxical effect: they provide a steady incentive for drug suppliers to remain in the trade and for new suppliers to enter. Supplier instead of being discouraged pursue high profits and keep the supply of drug up, and ensures that prices do not rise too high and thereby undermining the aim of war of drugs. As a result, war on drugs creates " Just enough pressure to inflate prices but not enough to keep its products from the market (Bertam et al., 1996). This has been also noted at the street level, drug unit price remain steady through the years (Grund, 1993, Charles, et.al.,1999).

The second flaw in drug war strategy is the self-reproduction of the trade, or the hydra effect. Attempts at eradicating drug production and dealing often spread the problem and make hard fought gains short-lived. This is seen at macro level with regard to transit routes at international level and micro level with regard to peddling networks. For example when Turkish authorities clamped down on illicit cultivation of opium production, drug organisations shifted production to the Golden Triangle region of South East Asia and to the mountainous regions of both sides of Afgahnistan-Pakistan border. Easy establishment of new routes or cultivating areas is possible because the main substances of abuse (heroin, cocaine and cannabis) are easy to grow, refine, transport and sell (Bertam et al.,1996). At the micro level in Mumbai city, new pockets emerge for heroin sale, when police action makes business difficult at the street level. Later, police action takes a back seat and drug dealing returns to old spots and new areas also continue to deal in drugs. Drug trade requires minimal initial investment and is quite profitable, as a result there is no dearth of new recruits willing to enter the field and try their luck. For drug trade provides them far better profits then other opportunities available to them. Another incentive is that given the perceived relative deprivation and unequal opportunities available for social mobility, many are tempted to opt for the path that is accessible for them. The sad reality is that in this process it is the marginalised who end up lower down in the ladder and hence more likely to be arrested for possession. These people become easy victims in the system as-

serting drug eradication, as there is no dearth of people willing to take risk for a better life they are easily disposable and replaceable. Those who are up in the ladder of drug trade maintain a physical distance from the drug or have the adequate resources to manipulate the system (Charles, et al.,2001). In the end the victims of white collar crime that who enter criminal networks for a better life in a biased system are the ones who bear the brunt of the law[10] .

V) Implication of punitive paradigm on scheme for understanding drug effects

Within the present perspective to drug abuse management there has been certain changes in earlier form of drug use management. To understand the impact of move towards cultural convergence within a punitive paradigm, a working plan is given as Annex 2 focussing on looking at changes brought in various constructs in order to redefine drug effects.

The attempt towards cultural convergence did change the earlier constructs that existed in cultural context to varying degrees and also tried to propagate new constructs. In certain areas the cultural use continued to persist, but here too the social network needed for obtaining the contraband changed, as a result even sadhus have to associate with drug traders to obtain their substance (Charles, 2001d).

In the case of drug use outside the cultural framework, the one that became most prominent was cannabis use among Flower Children. Member of the hippie movement used cannabis as a symbol of rebellion and when they reached the distant east searching for philosophies different from what west had to offer, they managed to transfer their non cultural use to local in tourists spots they visited. This brought about a different form of use even in places where cultural use existed. It has been seen from the case study of Nepal that tourism and banning of cannabis a result of international pressure only lead to complicating the situation and strengthens non-cultural use and drug trade (Fisher, 1975). The use of drugs as a expression of rebellion continues, but another view that has emerged is that drug is a means of escape whether from boredom or human suffering. Bernadi,L,R (1990) emphasised the need for prevention strategies to address the link between drug use and human suffering for any positive impact from drug control programmes.

The images evoked through new construct of a drug user are negative and a natural recipe for ensuring marginalisation and alienation. In fact way back in two decades ago Isidor Chein had argued that existing policies did little more than force "the addict from degradation to degradation" (cited from Bertam,et.al.,1996). At present the term addict invokes images of a deviant, criminal person who deserves to be punished and even incarcerated. Interestingly after spending millions of dollars within America and across the world, now the focus is to reduce marginalisation and for which attempt is being made not to redefine the basis for management but to attain it under the guise of 'dare to care'.

Other impacts on drug user that has been seen through punitive measures, directly or indirectly, has been on age, body weight, food preference, sexual abstinence. As a result of perception of drug a means of expressing rebellion or escape from life, the usual age group of drug user broadly fall under 15-30. This is different from use in cultural settings where except for symbolic use, traditional drug use is not encouraged among younger generations. (Charles, 2001(a)). This also ensures that the person losses out on any social skills that can ensure his/her place in a competitive world, for it is the period of either learning skills or getting experience for specific occupation. User falls out of the society's network, primarily because on identification, any representative of societal institution will classify him/ her as a addict (even if caught on the first or second occasion). Thereby they declare that s/he has to be treated till the desire to use drugs exists no more and then s/he will be slowly integrated back into the system.

As a result of marginalisation there has been an impact on food intake, body weight and sexual interaction. One of the steps taken by street level drug users has been to curtail food consumption, in Mumbai it has been noted that tea and Kari biscuit is the staple diet for many users. The tea is extremely sweet in order to get over bitter taste of brown sugar fumes. This is a different pattern from consumption of sweet along with cannabis intake as a means to strengthen the altered state of consciousness (Charles,et.al.,1999). A natural fall out of reduced food consumption is loss of body weight in a slow but sure manner.

With drug use being criminalised and the construct of a drug user being loaded with negative images, the user naturally wants to avoid being marginalised. The strong social constructs on addiction and addict have become acceptable to most, and even the user accept the self demeaning definition of an addict. Hence, on detection the user finds himself being viewed as an alien creature with all connotation of an addict being attached to him rightly or wrongly. Goffman, 1963 distinguished between three different types of stigma: physical, blemishes of the individual character and tribal stigma (race and religion). Addiction can be considered to fall under the second category, it creates a need to hide the habit in order to avoid being discredited. Hence, the person has to manage information about his drug use with great care, for s/he is often under stress to avoid being discredited or to manage tension

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[10] *According to Laniel, 2001, American prisons are populated mainly by young, black males (around 60% of inmates) who are poor without professional skills and live in cities. At present 6% of the 'market' is controlled by correctional co-operation and the rest by public sector of the `prison -industrial complex'. Prisons built in small towns have created jobs in numerous sectors of activity and represent a windfall for the poor whites of the area. For after spreading more than 1.5 billion to build the prison the state disturbs $425 million a year in operating costs. This is one of the largest infusions of public cash that has ever been made in the area stabilising the local economy. It is aptly summed up by Professor John Mason of New York University " Nowadays, the unemployed whites of the rural areas, who were ruined by the agricultural crisis of the 1980's and whose land has been bought up by large agribusiness co-operation, are paid to guard the unemployed blacks of the urban areas with the money of the social programmes that, precisely, were meant for blacks'.*

n being detected. This will make the erson avoid too close interaction, which lso includes interaction with opposite ex. The only other alternative for the erson is to go in for casual sex with trangers when s/he wants to. It has been een that users, especially males tend to go to sex workers, more so to convince hemselves of their sexual potency. In Mumbai this was done often after the erson, gives up drugs. Another alterna- ive available for them is to establish inks with opposite sex members who are lso involved in drug consumption.

While in the earlier forms of use, dif- ferent forms of positive mental status existed while consuming psychoactive substances in groups situation, but this not the case with regard to drug use at present. In most situations, other than those that continue to have legal sanc- tion, users have a strong sense of fear of being detected and the entire process is done in great secrecy. Except in case of street level use were the wall of separa- tion between US and THEM has become so obvious, that they do not care to hide their habit. Their entire life begins to re- volve around becoming a member of the marginalised group(Charles,et.al., 1999).

With regard to availability of past experience to act as a guide towards drug use management is not applicable, ex- cept as a way of strengthening marginalisation. In cultural context people with past experience were avail- able to guide the user through his/her drug experience in a constructive man- ner. In case of hard drugs the persons available are those who are extremely marginalised and as a result the body of knowledge available to the user is regard- ing ways to enhance his skills in order to be a part of the marginal setting. Of course there are ex-users groups who try to interact with drug users but their fo- cus is on making the user giving up drugs. Often they prefer to deal with users who have undergone treatment or want to be treated.

The present situation surrounding drug use ensures the user interacts more and more with other marginalised mem- bers and becomes encultured to the norms of different sub culture of marginalised members. They are oriented to different language with the aim of avoiding detection and for which they use inconspicuous words to describe items that otherwise evoke negative images. For example describing Nitravet tablet as vatana (peas). In addition to this oc- cupational skills are provided, for ex- ample how to be rag picker. This leads to situation where as Grund 1993 states " The more deviant the group (deviant from dominant behaviour, norms and values), is set apart and put under pres- sure, the more it will profile itself as a deviant group". It will slowly lead to the development of a highly separated, in- tra-depedent, monofocussed subculture where members are distrustful towards mainstream culture and this has been seen in street level drug use in Mumbai (Charles, 2001b).

Other then constructs regarding user constructs about dealers in drugs also underwent change in varying degrees. The administrative system made system- atic effort through media to create the image of a narcotics trader, the slight problem in this quest was that the only people about whom any profile is avail- able are those lower down on the ladder. In India, at times depending on who is in political power one or the other member of different groups involved in drug trade is focused upon. Invariably hype is around the worth of drug seized in inter- national market (indirectly emphasising the benefits of the profession), the ad- vancement in technology or methods of smuggling and very minimal details of the person caught. Other than for known underworld figures, the others are given vague description. At the same time jour- nalist skill shows less discretion when a petty peddler is caught. This type of bias in reporting about petty dealers and those in higher position has been high- lighted by Astroga (2001). There is also a discrepancy between the terms used by the establishment and those involved in trade and also community. In Mumbai a petty peddler may be known drug dealer by the establishment but for the drug trad- ing community and the community where sale occur the person is known as 'danda walla or danda walli' (business person).

As a result of punitive philosophy of management drug has become a lucra- tive contraband. It has led to drug trade being linked with other forms of organised crime, especially some of the other contrabands lost their lustre with changing policies of the government as a result of liberalisation. One of the other products that continue to be attractive at the international level is the diamond trade (Charles, et al. 2001).

With drug trade becoming a viable business venture, it has created different scope for different types of workers and professionals. To ensure the continuity of the business, different strategies have been evolved, one of them being to cre- ate different layers of workers, especially as this can help the more powerful mem- ber to distance themselves from the di- rect act of dealing. The person who does the final sales on the street faces the maxi- mum risk and comparatively lesser re- muneration. It has led to the inclusion of women and children in the workforce, for it avoids detection or harsh response. Unlike this in areas of cultivation, where the activity in nothing new the focus of the people is on making a living and they do not see the need to distance them- selves from the activity. It is changing in certain areas with police action, but there also it is the lower down worker who faces the brunt of law (Charles et al , 1999; Charles, et. al., 2001, Charles, 2001d).

Criminalisation has changed the so- cial construct, that surround a drug and it has further complicated the situation of trade and use. Being contraband the price of drug has increased but never beyond the capacity of the user popula- tion. In Mumbai, the price of brown sugar as remained at an affordable level of Rs, 10-Rs.15. At the same the purity at the street level has come down and this has made some users opt for injecting mode of consumption as they felt it would be more cost effective. The rea- soning being by injecting the drug di- rectly enters the system and gives a bet- ter high, only to realise later that this was true for only a short period. Later, their body adjusted to the drug and their re- quirement increased (Charles, et al. 1999). This has been noted in other coun- tries as well (Grund, 1996).

It is process of accessing the drug that makes a drug user interact with criminal networks and thereby strengthen his marginalisation. This is also true for can- nabis users but though it does not lead to

marginalisation as the cultural norms are still relevant. Culture does not club all drug users as one and emphasis the difference between different substances and also the need to emphasise the quantity taken per day and at a time (Charles, 2001a)

Drug substitution is another fall out of punitive approach. It has led to replacement of cannabis and opium by alcohol in some places. With media advertising on alcohol consumption, especially in a glamorous manner the younger generation has been opting for alcohol. In areas where there has been no cultural frame of reference for alcohol, it has led to excessive use. This shift is questionable when the harms of alcohol is far more than that of cannabis and especially so in places where culture controlled drug use. It has been also that opium users have shifted to drinking *doda pani*[11] to deal with opium shortage. In Pakistan, artificial scarcity of traditional drugs was created to encourage shift to hard forms of drugs (Muhammed, 1998).

According to Curra,J,(2000) social meanings, contacts and relationships mediate drug experience. This makes it necessary to evolve prevention strategies that can make use of local wisdom in reducing the adverse impact that can result from shifting to harder forms of drug use. Instead the existing programme repeats western philosophy and focuses on ignoring the earlier norms of control. Unless there is a mechanisms whereby earlier constructs are integrated into the present system, the prevention programmes may remain as isolated effort of concerned professional or as a way of gaining short term media attention for the concerned good work. Besides, intervention approaches become realistic only when drug abuse is seen as a problem of the community or group at the local level. According to Tongue,E, (1990) there is a need to go beyond making drug abuse a concern of professionals and to involve the community at large. In this context, intervention programmes that have evolved within the local reality in certain parts of India need to be looked at, especially as community based approaches

The overall impact on intervention programme as result of punitive measures has been to create scope in treatment and prevention in order to cloud the failure of war on drugs. One of the main events that has gained momentum has been maintenance programme on pharmaceutical products (often that of MNCs). There has been no effort even in developing countries that has a history of controlled use of opium, to conduct any experimental project on opium maintenance. It is interesting to note that in certain parts with scarcity of opium, hard drugs have found clientele even among the older population (Charles, 2001a).

Other than intervention targeting the user population, punitive paradigm changed the plan at the enforcement level. At the level of the user there is invasion of privacy and large amount of resources is spent on evolving mechanisms of detection that can be used at workplace and other institutions. This also will ensure that marginalisation increases and on detection the person can be isolated and terminated. In the present situation of human resource management where profit is the crux of the matter, such techniques can be used to also strengthening of insensitive policies towards the workers.

War on drugs have been used by many political parties across the globe to evade addressing issues of immediate concern that has no fast solution and cannot be explained away. For in case of drug war, one can falsely indicate temporary success as symbols of slow process of drug eradication. Example of Turkey can be used to highlight the success on drug war by ignoring the hydra effect. The arrest of number of persons and seizures can be used as another indication. With media becoming a business across the world and no longer a voice of the masses, there is no fear that social issues will be dealt with in depth or any rational opposition to such vested interest will be sustained.

Developing countries were not given the freedom to evolve plans that are appropriate for their reality, the focus was to spread the punitive philosophy. This process was ensured with the threat of economic sanctions against already impoverished nations who are struggling to deal with bias existing in area of trade relations. Often aid comes with strings attached that prove to be harmful to developing countries economy in long terms. All this, along with highlighting of materialistic lifestyle that are beyond the reach of common viewers in developing countries strengthens the feeling of relative economic deprivation. In order to control this volatile situation using the name of drug control programme the powerful nations can invade other nations and show total disregard for territorial rights. Another issue that can prove to be far more threatening then drugs is the move towards dealing with terrorism in the American high handed manner.

VI) Issues to be addressed

Any criticism about punitive paradigm is thrown over board before even being acknowledged, as a recipe for spread of drug use or by the reality that at present only a small percentage of the population use hard drugs as a result of punitive measures.

- One of the claims than is that people are not using drugs because the punitive measures has made drugs beyond their reach. This is not true for the drug price for hard drug is within the reach of many.

- Another justification is that since drug use is considered a crime, it has prevented spread of drug use. This is disproved by the increase in hard core heroin users. Besides if classification of a drug use as a crime has prevented drug use, why is this not applicable in case of cannabis use? Is this not indication that human beings are capable of thinking and taking their own decisions.

- If the system is concerned about the health of user population, why is the harm related to alcohol never highlighted, unlike less harmful cannabis. Alcohol industry has the option for advertising for their products, at times it is advertisement of another product on the same brand name. The viewer and ad-

[11] *A drink made from soaking opium pods in water overnight.*

vertiser knows that the indirect link is being reinforced. With globalisation a few groups and especially groups with international base are controlling the alcohol industry.

• Studies in other countries show that presence of clear defined formal norms (legal, institutional (eg educational) and informal norms that exist within interpersonal interaction can reduce harm related to drugs, prevent use at a young age and also prevent use of harmful drugs (Zinberg, 1996). If this is the reality of developed countires, why should not the formal and informal norms that controlled drug use in Indian reality be strengthened.

• Is not there ample evidence to show that there is a need to differentiate between cannabis and other drugs.

• Is it not time to create a space for sustaining cultural mechanism of control and providing legal options. The indirect pressure from international forum has even disturbed the legal distribution of cannabis and opium for preparation of traditional systems of medicine. Will this not affect the entire body of knowledge that existed for years? Will it not shift use of affordable medicine (eg. pain killer preparations/preparations to enhance immunity as against use of antibiotics) to pharmaceutical products, when there is tendency for pharmaceutical industries to raise price beyond the reach of many because of patent right under patenting the process?

• Channelling drive to mind altering substances (directly or in directly) will benefit the pharmaceutical industry. What prevents them from introducing new products and then removing it from the market when protests are raised against their products? During this period they would have made sufficient profit and that too legally.

• Can drug cultivation, trade and money laundering, continued to be viewed as a separate issue from overall development of developing countries? A rationale holistic approach addressing development problem without overriding vested interest will be the only solution to deal with man made predicament that has got itself linked to relative deprivation and attitude that "winners take it all".

• How long can society waste its scarce resources on strengthening a war it has already lost? And if it does continue, it may be time to sit up and ask "Who benefits and who pays for it". For in any other instance such investment will be viewed with scepticism by individuals familiar with organised crime.

• To end the paper, it would be appropriate to quote Goethe as cited in Huxley (1963), "We look at world through a ' half opaque medium of concepts, which distorts even given fact into familiar likeness of some generic label or explanatory abstraction'.

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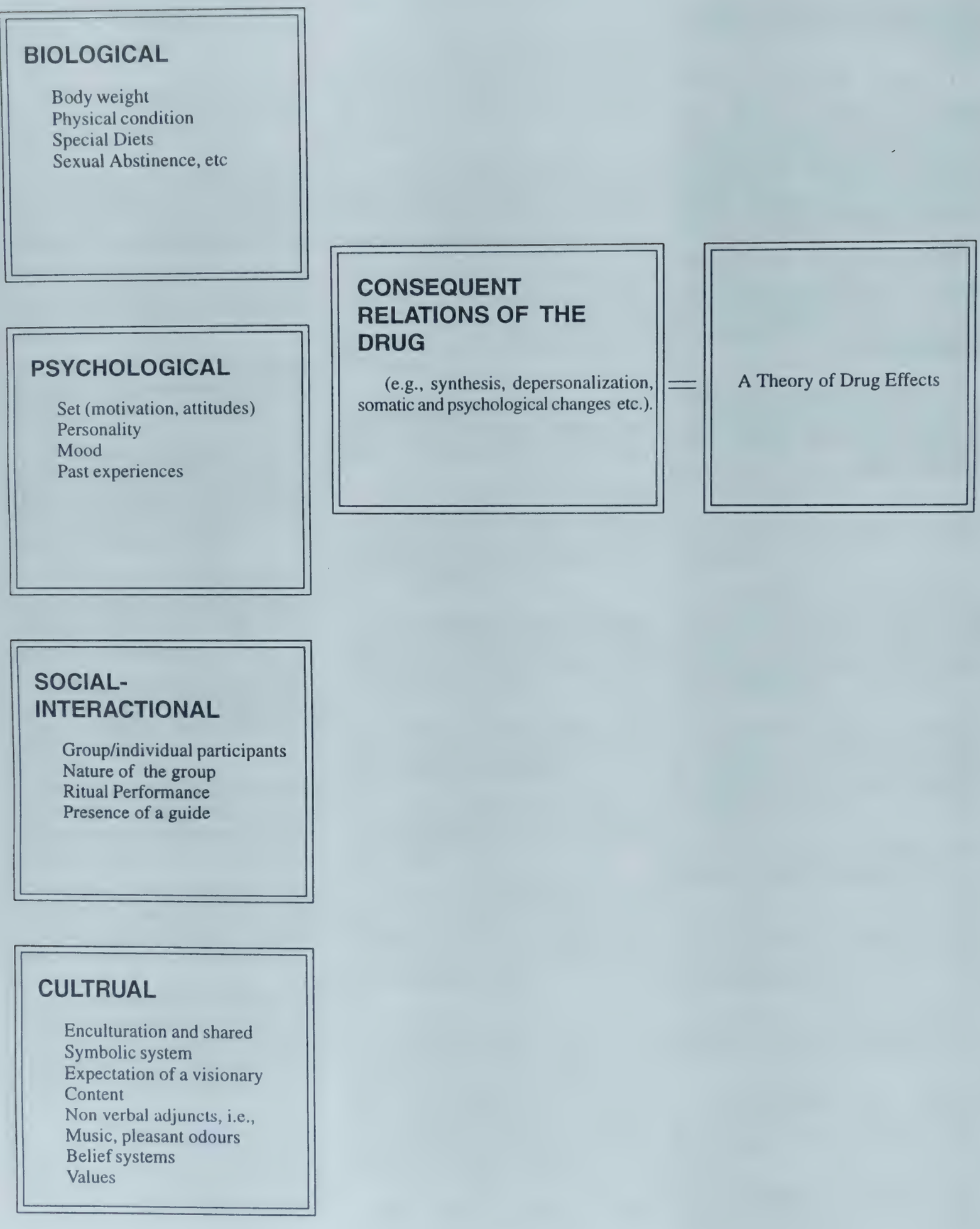
ANNEX 1


BIOLOGICAL
Body weight
Physical condition
Special Diets
Sexual Abstinence, etc
PSYCHOLOGICAL
Set (motivation, attitudes)
Personality
Mood
Past experiences
SOCIAL-INTERACTIONAL
Group/individual participants
Nature of the group
Ritual Performance
Presence of a guide
CULTRUAL
Enculturation and shared
Symbolic system
Expectation of a visionary
Content
Non verbal adjuncts, i.e.,
Music, pleasant odours
Belief systems
Values
CONSEQUENT RELATIONS OF THE DRUG
(e.g., synthesis, depersonalization, somatic and psychological changes etc.).
=
A Theory of Drug Effects

ANNEX - 2

CULTURAL CONVERGENCE TOWARDS Drug Eradication At supply and demand side

Criminalisation of Cultural Constructs

- *Drug*
- *Drug Use*
- *Drug User*
- *Drug dealer*
- *Control mechanisms*
- *Drive for culturally defined experiences*

Creating new Social Constructs

- *Drug as a contraband*
- *Drug Use*
- *Drug user*
- *Drug dealers*
- *Drug trade*
- *Control mechanisms*

Impact on Cultural Use

- *Even in places where cultural base exists the users have to interact with large scale dealers, who otherwise was not part of their social network*
- *Dealers became supporters of cultural use to facilitate trade*

Impact on Drug User (Harder forms of drugs)

Biological

- Age (starts use at a young age)
- Body weight (as a result of resource management for maintaining drug habit
- Special diet
- Sexual abstinence may occur (disinterest and fear of identification as a drug user)

Psychological

- Attitude (drug use as a expression of rebellion or as form of escape)
- Past experience (information may or may not be available)
- Mood fear (need to hide)

Social-Interactional

- Group/ individual use
- Place of use (secret)
- Nature of groups (marginalised individuals
- Guide (may or may not be present) Unstructured and provides information on ways to hide drug habit and also how to deal with marginatlisation.

Sub-Cultural Life Style

Enculturation to marginalised life style, especially to Values and belief around: **Us versus them**

Impact on Drug trade

- Creation of new professions
- Creating geographical distance (cultivating areas) and spatial distance (transporting and selling activities).
- New constructs regarding professional and workers at different level (a peddler is known in Mumbai street as dandawalla or dandawalli (business woman or man)
- Introduction of different types of workers at street level, women and children to avoid law
- Introduction of new strategy at street level, where links visible (creating layers for distancing and recruiting "disposable" individuals).

Impact on Drug

- Price maintained for hard drugs
- Quality maintained of derteriorates (impurity has led to shift to injecting behaviour as cost management)
- Use of technology to identify new forms of drugs and create stronger versions of earlier forms of drugs
- Changes in mode of consumption
- Accessibility of drug requires links with criminal netwroks
- Substitution of drugs

Impact on Control mechanisms

- Can led to territorial disregard under guise of drug control
- Sustains and facilitates intrusion into human being privacy (testing)
- Marginalisation and alienation
- Pushes the problem underground
- A means for maintaining class division (it is often the poor who are caught as peddler or users)
- Takes away right to be considered innocent till proved guilty
- Creates a myth for politician to use as per need of the situation
- Creates a chance for developed countries to seize the assets of traffickers from developing countries (not done till situation calls for it). For investment usually made where financial benefit is better.
- Creating a mechanism whereby appropriate tailored knowledge made available to public other findings are ignored left for future researches to refer.
- Monitoring research and intervention through resource control
- Creates a link between drug trade and other forms of organised crime.
- Creates a scope for people to get involved at the level of financing the trade (cash provided for short period) and at the same time able to keep a clean image.
- Gives right to certain Nations to o ensure that others follow their footsteps using the threat of economic sanction and Aid (which always comes with strings attached).

Impact on Intervention at demand side

- Underplay the contradiction that arises from considering drug sue as a crime and treatment philosophy of it being a biological, social and psychological problem
- Underplaying failure of punitive measures by providing scope for maintenance programme but at small scale.
- Facilitates shift to maintenance on pharmaceutical products (often produced by MNCs) instead opium or any other economically viable products.
- Channel drug use in long term to maintenance on pharmaceutical products and alcohol
- Incarcerate those who are visible symbols of failure of the policy. Or rather those who "refuse to be cured".
- Ensure class and race division continues.
- Create cheap labour by emphasising Role of ex-users and their need for safe environment
- Emphasises the role of risk taking in drug use, which is also crucial for independent thinking and questioning the system
- Ignore all concepts of liberty and right of other cultures to exist or adapt to change at their own pace and need.

Rates of Incidence of Crimes cases under OPIUM/NDPS Acts : select cities

State	1970	1975	1980	1981	1982	1983	1987	1988	1989	1990	1992	1993#	1994	1995	1996
Ahmedabad	-	-	-	-	-	-	2.3	3.8	1.4	1.0	NA	NA	0.9	0.8	0.8
Bangalore	-	0.2	-	0.2	0.1	0.1	0.4	-	3.6	1.8	NA	NA	1.9	1.3	0.6
Bhopal			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.2	4.1	3.6
Bombay	-	-	-	-	-	-	4.0	2.7	1.9	1.9	NA	NA	0.9	1.0	3.3
Calcutta	0.1	-	-	-	-	-	5.6	5.6	6.2	9.1	NA	NA	1.3	1.2	1.1
Coimbatore			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	17.8	10.5	5.0
Delhi	5.4	8.3	7.0	8.1	6.9	3.6	18.0	16.9	16.1	16.1	NA	NA	7.1	7.8	7.4
Hyderabad	-	0.3	0.1	-	neg.	neg.	0.1	-	0.5	0.6	NA	NA	0.8	0.7	0.2
Indore			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	3.2	2.5	2.8
Jaipur			NA	1.1	2.8	1.9	1.8	4.3	2.2	1.6	NA	NA	1.9	0.8	1.8
Kanpur	4.3	15.3	17.8	13.4	3.9	3.5	0.5	0.2	7.1	18.0	NA	NA	31.0	38.2	42.9
Kochi			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.7	2.3	3.9
Lucknow			NA	NA	2.7	2.6	15.2	11.9	4.4	6.8	NA	NA	1.2	14.9	22.6
Ludhiana			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	8.5	6.6	7.2
Madras	0.1	0.3	-	0.1	neg.	-	0.7	0.1	0.6	0.8	NA	NA	6.9	5.1	3.8
Madurai			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	13.6	12.0	121.7
Nagpur			NA	-	-	-	49.0	127.8	37.7	108.4	NA	NA	4.6	2.6	2.2
Patna			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.1	-	-
Pune			NA	-	-	-	10.8	8.3	6.4	6.0	NA	NA	1.5	1.1	0.5
Surat			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.8	0.5	0.8
Vadodra			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.7	1.2	1.1
Varanasi			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	43.0	41.9	29.2
Vishakapatnam			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.1	0.1	0.2

* Figur less than 0.05 i.e. negilible

Since the national average is not available for the year 1993, we took the overall a rate of 2 .0 as the base for computing endemicity.

Source: National Crime Research Bureau, *Crime in India,* New Delhi: NCRB.
Rate is computed by dividing the number of crimes by 100,000 population of the respective State/city in that respective year; i.e. rate is incidence per lac population.

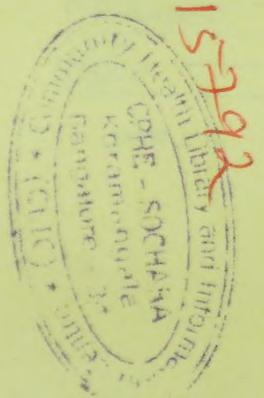


Table 1.1:

Rates of Incidence of Crimes cases under OPIUM/NDPS Acts : States and Union Territories and select cities

State	1970	1975	1980	1981	1982	1983	1987	1988	1989	1990	1992	1993#	1994	1995	1996
A.P.	-	Neg.	*	-	neg.	neg.	-	-	-	0.2	0.2	0.4	0.6	0.8	0.8
Arunachal P.	-	0.7	0.2	1.3	1.5	0.6	0.7	0.6	1.8	1.7	2.4	1.7	0.9	1.1	0.5
Assam	0.2	0.2	0.1	-	0.1	0.1	-	0.1	0.2	0.5	0.6	0.8	0.6	0.5	0.5
Bihar	-	Neg.	*	-	neg.	neg.	-	0.1	0.4	0.1	0.1	0.1	0.2	0.2	0.2
Goa	0.9	-	-	-	-	-	8.5	8.1	5.2	3.9	2.4	2.1	1.6	1.3	3.1
Gujarat	-	-	-	-	-	-	0.5	1.2	0.8	0.6	0.6	0.6	0.8	0.6	0.5
Haryana	13.1	29.7	17.7	17.8	18.5	19.2	6.9	6.5	7.1	5.6	5.2	7.0	6.8	6.8	6.9
H.P	1.5	0.7	0.9	1.2	1.0	1.2	1.4	2.0	1.4	1.6	1.7	1.8	1.9	1.5	1.6
J & K	-	Neg.	-	-	0.1	0.1	0.2	2.0	2.6	50.5	0.4	0.6	0.5	0.6	0.7
Karnataka	-	Neg.	*	0.1	neg.	Neg	0.1	-	0.3	0.3	0.3	0.5	0.5	0.4	0.2
Kerala	-	Neg.	-	-	-	-	-	0.6	0.6	1.7	1.2	1.0	0.9	1.0	1.4
M.P.	0.8	0.7	0.6	0.7	0.6	0.5	0.3	1.4	0.5	1.4	1.8	2.1	1.9	2.0	1.6
Maharashtra	-	Neg.	*	-	neg.	neg.	1.8	4.4	2.4	2.8	1.8	1.4	1.2	0.9	1.2
Manipur	0.6	0.3	-	0.1	0.1	0.1	17.0	14.1	16.0	13.9	15.9	10.9	11.1	3.2	4.2
Meghalaya	-	0.3	-	-	-	0.1	0.7	0.5	0.4	0.4	0.8	1.0	1.5	1.0	0.8
Mizoram	-	-	-	-	0.2	-	1.7	10.4	6.4	7.6	26.1	21.4	12.6	8.5	6.5
Nagaland	0.2	2.4	0.3	1.3	0.1	0.2	3.4	5.0	11.1	12.4	11.3	16.8	11.0	8.3	10.3
Orissa	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.6	0.6	0.4
Punjab	49.5	43.7	57.9	56.6	57.4	56.0	8.6	7.8	8.2	6.9	5.9	7.6	8.2	6.9	7.8
Rajasthan	1.4	1.5	1.7	1.6	1.4	1.1	1.7	1.6	1.6	1.8	2.0	1.8	2.0	1.3	1.2
Sikkim	-	-	-	-	-	-	-	-	-	-	1.9	2.5	3.3	3.4	1.3
Tamil Nadu	0.3	0.3	0.1	-	neg.	neg.	1.8	2.7	3.7	2.6	6.3	4.6	4.6	3.8	5.8
Tripura	-	-	-	-	-	-	-	-	0.1	-	0.3	0.4	0.2	0.3	0.2
U.P.	0.6	1.2	1.5	0.9	0.7	0.6	1.0	1.1	1.3	2.1	6.9	6.0	5.3	6.0	5.5
West Bengal	-	-	Nil	Neg	Neg	Nil	0.3	0.3	0.5	0.6	0.5	0.6	0.5	0.5	0.4
A & N Islands	1.1	-	0.5	1.6	1.5	-	-	2.3	3.3	2.4	1.0	0.3	0.9	0.9	0.9
Chandigarh	37.1	26.1	19.2	23.6	17.4	21.2	1.4	1.7	3.0	2.5	1.8	1.5	0.9	1.5	1.6
D & N Haveli	-		-	-	-	-	-	-	-	-	-	-	-	-	-
Daman & Diu	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Delhi	5.4	7.9	6.5	8.1	5.5	3.6	17.4	16.7	15.5	15.7	9.1	7.4	6.6	7..3	6.8
Lakshwadeep	-	2.9	-	-	-	-	-	-	-	-	-	-	-	-	-
Pondicherry	-	-	1.5	0.3	0.8	0.5	0.6	1.0	0.8	-	0.8	0.6	0.1	4.7	0.2
TOTAL INDIA	5.1	2.1	2.2	2.1	2.1	2.0	1.2	1.7	1.6	1.7	2.6	NA	2.3	2.2	2.3

Table continued

Rate is computed by dividing the number of crimes by 100,000 population of the respective State/city in that respective year; i.e. rate is incidence per lac population.

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